

THE STUDENT EXPERIENCE OF PRECEPTORSHIP IN NURSING:

Learning through guided participation

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ABSTRACT

Preceptorship has been introduced into pre registration nursing courses to facilitate student learning during periods of clinical practice. Empirical evidence to support the use of preceptorship in the UK context is, however, limited. This study aims to examine the perceptions of student nurses and illuminate their experiences of preceptorship. The purpose is, to develop a theoretical understanding of the practice, to analyse the influence of preceptorship on students' learning, and to inform future planning.

A qualitative research approach was adopted to explore and interpret student nurses' experience of preceptorship and learning in the clinical setting. Semi-structured interviews were the predominant mode of acquiring information from twenty five student nurses in one college of nursing. The principles of grounded theory were used to guide data collection and analysis in the first phase of the study. However, questions arising from the data directed the subsequent analysis towards existing theories of learning and cognitive development. A framework of explanation, based on sociocultural theories of learning, was brought to the second phase of the study. The student experience was then interpreted and the process of learning and cognitive development in practice explained within this framework.

The study findings emphasise that learning to become a nurse requires access to, and participation in, the diverse practices of nursing. Preceptorship not only provides a means of sponsorship into the complex social environment of 'nursing', but also opportunity for learning through collaboration with experienced practitioners in care delivery. The process of entry, described by the students as 'fitting in', to the new cultural situation of nursing and the impact of sponsorship on learning are identified. The concept of 'guided participation' (Rogoff 1990) is used to interpret and explain the complex processes involved in learning through practice.

Previous studies and earlier literature identify role modelling as a central feature of preceptorship. Findings from this study, however, point up the limited extent to which social learning theories such as role modelling are useful in explaining the influence of preceptorship on learning. The works of Vygotsky (1978), Rogoff (1990) and Lave and Wenger (1991) are used to explain the mechanisms through which social interaction facilitates cognitive development. This thesis highlights the importance of social and cultural influences on the appropriation of knowledge by nursing students. The findings of the study provide evidence to inform future planning, particularly in relation to practice based learning support in nurse education.

Declaration

I hereby declare that this thesis has been composed by myself and that the research on which it reports is my own work.

A.M. Colette Ferguson
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CHAPTER 1

CHAPTER 1

Introduction

The past decade has witnessed major changes in the education of nurses, not least through the implementation of Project 2000 and the subsequent Diploma of Higher Education in Nursing. With the move into higher education, the process of pre-registration nurse education has changed beyond recognition from that of ten years ago. One of the most significant changes relates to the supernumerary status of the student nurse during periods of clinical practice, an issue which has stimulated many questions regarding responsibility for supervision and learning during placements. While each college of nursing was required to develop and implement a support system for students during clinical practice, evaluation studies of Project 2000 have highlighted inconsistency in the quality of support received by students. The recent UKCC commission for Nursing and Midwifery Education, 'Fitness for practice' (UKCC 1999), recognises the crucial role of the mentor in helping students learn from practice as well as the inconsistencies in the quality of support provided.

1.1 Background

It is widely recognised in the nursing literature that the mere presence of the student in the clinical area does not in itself ensure progress in learning. Writers such as Ogier (1981), Orton (1981), Fretwell (1982; 1985), and Gott (1984) have questioned how much students can, and actually do, learn during periods of clinical practice. Melia (1987) contributes to this work when exploring the socialisation of nursing and in particular the issue of students as workers. While these writers provide important insights into student learning, and the characteristics of wards as learning environments, their research was carried out in a context in which student nurses were contracted to provide service during practice placement. The radical changes in nurse education and in particular the status of the student nurse during clinical

placement, demands further research to illuminate the factors which influence the process of learning in practice.

Preceptorship

Preceptorship is defined as: 'an individualised teaching learning method (in which) each student is assigned to a particular preceptor .. so that he or she can experience day to day practice with a role model and resource person immediately available within the clinical setting' (Chickerella and Lutz 1981 p.107)

The assumption underpinning preceptorship is that the one to one relationship will provide an effective means of facilitating learning during clinical practice placements. A review of the literature, however, identifies that at present there is limited empirical research to support the initiative in the UK.

The Study

This study evolved from personal and professional interest in the way in which student nurses learn and develop their practice in the clinical field. My specific interest in preceptorship and learning support roles began with the preparation for, and implementation of, the reforms of nurse education, Project 2000 (UKCC 1986). As a member of a 'placement advisory committee', I was involved in establishing and developing a course to prepare practitioners for their role in supporting students during periods of clinical practice. Following the implementation of the 'Diploma of Higher Education in Nursing' in 1992 these 'preceptorship' courses continued. Each course was evaluated and continuously developed in response to the preceptors' needs. No formal research, however, was carried out. Recognising the dearth of empirical research in the UK to underpin, not only the preparation of preceptors, but also the practice of preceptorship per se, the decision to undertake this research was made in 1995. Since the preceptorship system had been in place for three years and the aim was to support student learning in practice, it was considered that a study which identified the students' experience of preceptorship, and the influence this has on learning, would be a priority.

1.2 Context

The context of the study is a College of Nursing and Midwifery in Scotland which has since become part of a higher education institution. The students involved were undertaking the 'Diploma of Higher Education in Nursing'. This is a three year full time course of study preparing the individuals for registration as either adult or mental health nurses. The course was organised in six parts (semesters), each of six months duration. The first three course parts constituted a common foundation programme, the next three the adult or mental health branch. Fifty per cent of the course was based in clinical practice placements. Of this practice element equal weighting was given to both hospital and community experience. During the early course stages each placement was normally four weeks in length. In the latter stages six weeks were spent in two different acute areas and ten weeks in a community placement. In each placement the student was assigned a named preceptor.

Within the college a professional development strategy was implemented to prepare registered nurses for their role in supervising and supporting students. Experienced staff nurses were identified as the group most suitable to be preceptors and the support required by care area managers recognised. Two different types of courses were developed, one to prepare for the preceptor's role and one to prepare care area managers for supporting preceptors and creating an educational environment.

Essential content for the preceptorship courses was gleaned from the American literature, however, the focus remained on the changing nursing climate in the UK. The courses were based on the premise that all potential preceptors require:

- insight into the students' course, philosophy and rationale;
- understanding of the principles of adult education and their application to the practice of nursing;
- knowledge of teaching/learning strategies;
- appreciation of the need to provide an environment conducive to learning;

- understanding of feedback, assessment, goal setting and evaluation.

As well as preparing both preceptors and care area managers, an individual lecturer was assigned to each clinical area. In addition to supporting students, the lecturers' responsibility extended to supporting practitioners in creating a clinical environment conducive to learning.

1.3 The Research Questions

The study evolved from, and was guided by, the underpinning questions: *Does preceptorship facilitate student learning?* and if so, *In what way?* The aim was to examine the student nurses' perceptions of preceptorship and illuminate their experiences. The purpose was to develop a theoretical understanding of the practice and illustrate the influence of preceptorship on students' learning. Information and evidence on which to base future planning would then be available.

1.4 The Research Approach

A qualitative research approach was adopted to explore and interpret the students' experience of preceptorship and learning within the clinical setting. Semi structured interviews were the predominant mode of acquiring information from twenty five student nurses. The principles of grounded theory were used to guide data collection and analysis in the first phase of the study. Questions arising from the data, however, directed the subsequent analysis towards existing theories of learning and cognitive development. A framework of explanation, based on sociocultural theories of learning, was brought to the second phase of the study. The student experience was then interpreted and the processes of learning and cognitive development in practice explained within this framework.

1.5 Presentation of Data

Following this introduction to the study, chapter two will present a review of the literature. The literature review indicates the focus of relevant literature, and aims to identify any gaps and inconsistencies in current understanding of the topic. Previous research relating to practitioners' influence on learning will be revisited before exploring the specific literature which pertains to preceptorship and learning support roles. An attempt will be made to differentiate between mentorship and preceptorship as a means of providing conceptual clarity and justification for the use of preceptorship in the pre-registration nursing course undertaken by the students in the study. Since preceptorship is relatively new and unexplored in the UK context, an overview of the American literature will identify areas of research and issues arising. This will be followed by the UK literature which addresses preceptorship both directly, through small scale studies, and indirectly, through evaluations of Project 2000 and commissioned reports. As this current study focuses on the students' experience in the clinical context, the final part of the review will explore literature from both nursing and education sources which informs the influence of learning environments and role modelling.

Chapter three will introduce the theoretical framework which provides a structure within which the data will be analysed and explained. This theoretical framework is based on a sociocultural perspective on learning and development. The seminal work of Vygotsky (1934/1978) and the more recent work of Rogoff (1990/1993) and Lave and Wenger (1991) will be introduced and their relevance to the current study identified. Unlike many other studies, where the theoretical framework is established at the beginning, the initial data collection and analysis guided this present study towards the particular theoretical framework. The process by which this happened will be explained in the following chapter on the approach to the study.

The approach to the study, the methodology and the process are explained in detail in chapter four. Two distinct phases are identified. The way in which the principles of

grounded theory were used to guide data collection and analysis, and a 'watershed' in which questions arising from the data changed the direction of the study, will be clarified. In order to justify the change in analytical direction, the somewhat unusual step of identifying some of the preliminary findings and emerging issues before presenting the findings chapter will be taken.

Chapter five will then provide a full account of the findings. The student experiences of preceptorship will be described, discussed and to a limited extent explained within five main themes: the preceptor; the learning environment; student needs; the process of learning; and student development. Throughout this chapter an attempt is made to illuminate and 'bring alive' the student experiences through the extensive use of direct quotations. Some issues are addressed within more than one theme so that they can be viewed from different perspectives. For example, the characteristics of the preceptor-student relationship are identified under the theme 'preceptor' but addressed again as influences within 'the process of learning'

Chapter six will present an interpretive analysis of the student experiences within a sociocultural theoretical framework. The work of Vygotsky; Rogoff; and Lave and Wenger, already introduced in chapter three, will be used to interpret and explain the student experiences from a sociocultural perspective. The concepts of '*legitimate peripheral participation*' and '*guided participation*' will be introduced to illustrate the complex processes involved in '*fitting in*' to the culture of nursing and learning through practice. The social and cultural influences on the appropriation of knowledge by student nurses will be identified.

Chapter seven concludes the thesis by presenting issues arising from the study and identifying pointers for policy and practice. The value of the research to the current political and professional debates on nursing education is recognised. The limitations of the study are acknowledged and suggestions for further research put forward.

CHAPTER 2

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

At the beginning of this study a very broad review of the literature was carried out. As the intention at this time was to utilise a grounded theory approach, the disadvantages of carrying out a pre-study review were acknowledged. Hickey (1997) suggests that reviewing literature on issues not emerging in the data could result in the researcher focusing the research problem on areas that the literature suggests are important rather on those that the data reveal to be important.

The aim of this early review, however, was to establish the extent of literature, the focus, the research available as well as to identify any gaps and inconsistencies. The literature search was carried out both manually and with computer assistance. Weekly hand searches were carried out of the current journals in both the nursing and education sections of the library. A snowballing technique was used to follow up relevant references. Key words, 'preceptorship' and 'mentorship' were used to search information in the following databases: BIDS, CINAHL and ENB Health Care Database. As well as preceptorship and mentorship, references associated with practice based learning and learning per se were reviewed.

At this point in time (1995) much of the British literature on preceptorship focused on the confusion between the concepts of mentorship, preceptorship and clinical supervision as well as the absence of empirical research to support the implementation of any such system. A growing volume of literature presented anecdotal material describing different experiences. In contrast to the British context, a review of American literature, where preceptorship has been more widely

utilised, identified a move from description towards evaluation and measurement of the effect of preceptorship programmes.

As this present study progressed, themes arising from the data analysis were the driving force behind a more focused literature search. Literature from the sociocultural field of education was sought and reviewed. For clarity of exposition the sociocultural literature will be presented as the theoretical framework in chapter three. In order to develop understanding of the student experience of preceptorship, however, as well as the context of this experience, the following review focuses on:

- The practitioner's influence on student learning
- Preceptorship and learning support roles
- Overview of preceptorship literature from:
 - USA and Canada
 - UK context
- The learning Environment
- Role Modelling

2.2 The practitioner's influence on learning

The influence of the practitioner on student learning has been well recognised throughout nursing's history. This review will, however, be limited to the past two decades, 1980 - 1999. This time span has been selected because it allows for reflection on the changing emphasis on the role of the practitioner before and after the reform of nurse education and the implementation of the Project 2000 proposals (United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) 1986).

Background

A substantial body of literature emerged throughout the 1980's which explored the ward learning environment in nurse education and the role of the practitioner

(Fretwell 1980; Orton 1981; Ogier 1981). The system of training in the UK during this period was largely an apprenticeship-style scheme in which the student was employed as a worker under a contract to provide service. The assumption underlying this system was that trained nurses would teach and supervise learners during the normal course of their work. This assumption was far removed from reality for the students who spent the majority of their time working either on their own, with auxiliaries or with other learners (Melia 1981). In fact, Jacka and Lewin (1987), identified that students spent 50% - 75% of their time working alone.

Melia (1981; 1987) provided evidence of the student nurses' experience of working and learning. She questioned a system where three years preparation was spent as short spells in different clinical areas learning how to 'fit in' and 'get through' the work allocated, taking little responsibility for care planning and decision making. Rather than preparing the student for the role of staff nurse, 'it prepares them for picking up different ways of working and for 'fitting in' with any given system of nursing and importantly, to 'get the work done' (Melia 1987, p.175).

Fretwell (1980) carried out a study into ward teaching and learning, the results of which challenged the assumptions on which the apprenticeship system of nurse education was based. Using questionnaires, followed by interviews, she studied 87 learners on 15 wards of 3 hospitals. She used similar questionnaires to ascertain the views of sisters from 11 of the wards. The results showed that teaching and learning varied with the nature of the work, the learners' stage of training and the length of time spent in the ward. Basic nursing was found to be more routinised than technical nursing and there was less teaching and learning during this type of work. An ideal learning environment was seen as one in which: 'the educational needs of learners are met .. and the key features are teamwork, negotiation, good communication, and the availability of trained nurses during work and when work is done' (p.73). The sister emerged as the key figure who creates and controls the learning environment.

One feature of Fretwell's research particularly significant to the present study was that it uncovered aspects of the ward environment which appeared to be inconsistent with learning. It concluded that a system which has traditionally developed to get the work done, produces an environment which is the antithesis of a learning environment:

A system of task allocation, in which tasks are allocated to workers according to a place in the hierarchy, takes trained nurses away from learners who are most in need of help ... 'routinisation' of work contributes to an automatic job performance which stifles a spirit of enquiry' (Fretwell 1980 p.73).

This study acted as a catalyst for further work by Fretwell. An action research project followed which aimed at improving the ward learning environment. A pilot study was carried in one 'good ward', identified from the previous data, and desired changes identified. After six months the project extended to ten wards including the pilot ward, change objectives and action to be taken were identified. Staff completed questionnaires after six and twelve months. While the results demonstrated that sisters and nurses were able to improve the environment as well as their performance, external constraints and implications for policy making were highlighted (Fretwell 1983).

Several important studies carried out throughout the 1980's reinforced the concerns raised in Fretwell's work and contributed to the knowledge of student learning in practice, for example: Melia (1981); Orton (1981); Ogier (1981); Gott (1984); Reid (1985); Ogier and Barnett (1986). A number of themes emerged from these studies which have a direct effect on student learning: the influence of the ward sister; the organisation of work; the 'atmosphere'; interpersonal relations and communication. Alexander (1983) identified and explored discrepancies between theory and practice in nurse education and raised concern about the quality of clinical teaching in wards. Each of these studies raised serious questions about how much students can and do learn during clinical placements. Common to each were the constraints embedded in the apprenticeship type system of training. The need for change was consistently demonstrated.

The case for change was realised within the reform of nurse education, Project 2000 (UKCC 1986). The deficiencies in the preparation of nurses recognised in the previous studies were addressed. The inadequate levels and quality of support, supervision and instruction received by student nurses in the clinical area contributed to the case for change in the overall pattern of preparation for nursing. One of the key features in the reform of nurse education was the introduction of supernumerary status for students. This changing status, from worker to learner, was proposed as an essential factor in enhancing the quality of the learning experience and the overall educational standards.

Changing culture of nurse education

In contrast to the focus on the case for reform, the literature of the 1990's presents a number of evaluation studies reporting on Project 2000 and the degree to which new staff nurses are prepared for the reality of nursing practice. As well as focusing on preparation for practice, the recent literature has widened the debate to reflect the changing culture of nurse education. The changing health care climate and increasing complexity of health care presents different demands for the role of the nurse. Decreasing length of hospital stay and the corresponding increase of acute care in the community, as well as the emphasis on health promotion, all impact on the nurse's role and function. It is consistently articulated in the literature that nurse education must address these demands by preparing practitioners with the knowledge, skill and competence required to meet the complex and changing requirements of patient care.

In an attempt to meet the changing demands and complex requirements of patient care more diverse learning environments including community and social settings are recognised and utilised in pre-registration nursing curricula. No longer is clinical practice for students predominantly hospital based. The influence of the practitioner on student learning, however, remains clearly evident today (Phillips et al 1996; Newton and Smith 1998). Indeed, almost 90% of students in a descriptive study carried out by Newton and Smith accredited the learning of clinical skills to the

mentor or other staff nurses. While the central issue in this study by Newton and Smith was concerned with the role of the 'personal tutor' in supervising students in practice placement, the influence of mentors and other staff nurses was recognised. The value of critiquing Newton and Smith's research further within this review is limited and would be more appropriate within the prolific body of literature now pertaining to the role of the nurse teacher in practice which is not within the remit of this thesis.

The changing status of the learner, from worker to supernumerary student, with the concomitant recognition of the need for a formal learning support system in practice, have refocused the discussion regarding the role of the practitioner in facilitating student learning during periods of clinical practice. An abundance of literature now exists which explores the role of the practitioner in facilitating student learning in both hospital and community settings.

2.3 Preceptorship and learning support roles

The need for support for students during clinical placements was recognised within the reform of nurse education (UKCC 1986) as well as by The National Boards for Scotland, England, Northern Ireland and Wales. Marriot (1991) acknowledged this as particularly important because the new supernumerary status of students aims to change the focus of a student's clinical experience from a service driven one, to one that emphasises and meets educational needs.

Since the implementation of Project 2000, and the Diploma of Higher Education in Nursing, mentorship and preceptorship systems have been widely implemented throughout the UK. Oliver and Enderby (1994), however, observed that the terms have been used synonymously. This seemingly arbitrary choice of usage has served to exacerbate the confusion which already exists between these two concepts. The

confusion between mentorship and preceptorship has been well documented within the nursing literature since the mid 80's when Hagerty (1986) referred to the 'Definition Quagmire'. This confusion persists and is still very evident today (Gray and Smith 1999; Watson 1999; Watson and Harris 1999). The situation has not been helped by the UKCC and the National Boards who, while endorsing the use of support systems, in practice failed to present clear guidelines or concept clarification. The English National Board for Nursing, Midwifery and Health Visiting (ENB), for example, advised that a mentor should be someone selected by the student to assist, befriend, guide, advise and counsel, but who would not normally be involved in the formal supervision or assessment of that particular student (ENB 1989). The UKCC also supported the use of mentorship as a pre registration support system and defined a preceptor as: 'an experienced nurse, midwife or health visitor who supports and role models for newly qualified registered nurses' (UKCC 1993).

It is now more than a decade since this definition quagmire was referred to by Hagerty. A national study of Project 2000 programmes (White et al 1994) found that role titles and role functions did not always correspond to one another, resulting in what they described as a 'tautological maelstrom'. Two recent Scottish studies commissioned by the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), May et al (1997) and Watson & Harris (1999), acknowledge the confusion and use the term 'mentor' when discussing the individual nurse who supports students in placement. The use of the term 'mentor' in each of these reports is justified by reference to The UKCC (1997) who define 'mentors' as 'those registered nurses, midwives and health visitors who take on the role of providing support, guidance and role modelling for students in the practice setting' (p.1). It is clear from each of these reports that role titles and role functions do not always correspond.

It is not the aim of this thesis to contribute to the confusion surrounding mentorship and preceptorship or the role ambiguity regarding those who support students during clinical placement. Nor indeed is the aim to extend the debate on terminology, rather it is to develop understanding of the student experience of support in practice and how this influences learning. Nevertheless, before continuing with this literature review it seems worthwhile at this point to digress a little and attempt to resolve the confusion by differentiating between these two support systems and providing some conceptual clarity for the use of preceptor in this present study.

Mentorship

Historically the term mentor derives from the classic, Homer's *Odyssey*, wherein Mentor was the name of the wise, older man who was entrusted with the guardianship of the young Telemachus. The roles of advisor, tutor, support person have since become accepted elements in the concept of mentorship. Much of the modern literature about mentoring (Clutterbuck 1985; Hunt and Michael 1983) is related to the business world where, as an organisational phenomenon, it has gained great popularity, especially in the USA. In spite of the variety of definitions much of the literature on the subject appears to agree that mentorship has its origins in the concept of apprenticeship.

Within the nursing literature the idea of the older, wiser, more experienced person guiding and nurturing the younger, inexperienced person has been widely explored. Vance (1982) describes mentoring as a specific type of nurturing support system and cites mentorship as an intense, paternalistic, powerful means of shaping the careers of protégés. Vance and Davidhigar (1988) describe the mentor relationship as intense and emotional and identify the underlying model as being paternal. Darling (1984) discusses the characteristics of mentorship and identifies three absolute

requirements for a significant mentoring relationship as: attraction, action and affect. She goes on to explain that it is vital that both people like each other. Interestingly cognitive abilities are not mentioned as a prerequisite which highlights the focus on the interpersonal rather than teaching function of the role.

Burnard (1990) questions the appropriateness of mentorship within the context of pre-registration nurse education. He suggests that the mentor relationship - given the mentor is older and wiser and the student younger and more impressionable - is more likely to foster dependency and conformity and as such does not seem compatible with the notions of adult education which form the basis of most nurse education programmes.

Woodrow (1994) adds another dimension to the appropriateness of mentorship in pre-registration nurse education when he explores the role of the mentor in assessment. Assessment, he suggests, presents profound conflict in the mentor/student relationship. Assessment emphasises the need for judgement which would conflict with the classic mentor denotation and certainly with Darling's requirements. A contradiction exists between mentors providing support and acting as role models for students, and assessors remaining impartial, if informed judges.

The work of Palmer, 1987, may be helpful here. Palmer (cited in Morton-Cooper and Palmer 1993) identifies three subsections to the mentor role:

- personal element - where the mentor encourages confidence, creativity, risk taking and fulfilment of potential within the student.
- functional element, which deals with the practical issues of teaching, instruction, support and advice giving.

- development and enabling element which encompasses interpersonal skill development, networking and sponsorship.

Ellis (1993) suggests that by concentrating on the functional element exclusively, the preceptor role emerges.

Preceptorship

The word Preceptor originated in 15th Century England where it was taken to mean tutor or instructor (Peirce 1991, Oxford English Dictionary 1990). It was first classified in the nursing index in 1975 when it became widely used in USA and Canada as a response to concerns about the disillusionment and frustration of new graduates when they entered nursing service - a phenomenon described by Kramer (1974) as reality shock. It was suggested that one way to ease this would be to expose nursing students to the real world of nursing when they are students and preceptorship was the chosen means to meet this goal. The most often cited definition of Preceptorship is that offered by Chickerella and Lutz (1981): Preceptorship is . . .

an individualised teaching learning method (in which) each student is assigned to a particular preceptor . . . so that he/she can experience day to day practice with a role model and resource person immediately available within the clinical setting (p.107)

Shamian and Inhaber (1985) describe the preceptor as:

a unit based nurse who carries out one to one teaching of new employees or nursing students, in addition to her regular unit duties (p.79)

The preceptor is therefore the nurse who teaches or instructs by demonstrating and applying 'precepts', precept being defined as 'a maxim', a general rule for action (Collins 1982). Given that nursing practice is more than the sum of its component parts this would appear to be a potentially invaluable teaching/learning strategy.

Such an assumption of course requires exploration and substantive research to support, or refute, it.

Concept Clarification

Clarification between mentorship and preceptorship is evident in two recent American publications by Hayes (1998) and Barnum (1997). Hayes identifies preceptorship as a short term, assigned relationship with specific goals to be achieved. Mentorship represents a longer and voluntary relationship. Barnum proposes that teaching, precepting and mentoring are three subsets in the instructing relationship, with precepting falling somewhere between teaching and mentoring on the continuum. Unlike teaching, which *may or may not* occur on a one to one basis, mentoring essentially takes place in a one to one relationship. Here a senior and a more junior person voluntarily enter a relationship. 'What gets conveyed in mentorship cannot be defined in a curriculum, the content addressed changes as the relationship grows and people change' (Barnum 1997, p.2). Barnum goes on to differentiate between mentoring and precepting. Preceptorship, like mentorship, is a one to one relationship. Even if a person precepts more than one student, *each relationship is handled in a one to one manner*. Unlike mentorship, preceptorship is usually contractual or formally arranged and is sustained for a much shorter time. There are clear learning goals to be achieved in preceptorship and these goals are primarily professional, not exclusively personal.

In summary a classic mentoring relationship develops and grows between two individuals over a long period of time. Such relationships may last for many years and provide professional and emotional support. The term 'mentor' should therefore be reserved for mutual, longer term relationships between two people, one of whom is significantly more experienced than the other, suggesting the recognition of

potential and a concern for the individual's well being, advancement and general progress. Preceptorship on the other hand is more clearly defined, more concerned with teaching and learning aspects of the relationship and working towards planned learning outcomes. Given the diversity and relatively short duration of each practice placement it is argued that a planned 'preceptorship' is more appropriate in pre-registration nurse education. However, research within the UK context is required to support or refute the practice. A selective review of literature pertaining to preceptorship will now be introduced.

2.4 Overview Preceptorship Literature

In the UK nursing literature there is a growing body of material relating to preceptorship. Until recently, however, this has been mostly descriptive and anecdotal with limited evidence of empirical data to support or refute the practice. As discussed in the previous section, most of the relevant literature throughout the 1980s and early 1990s focused on the confusion between the concepts Mentorship and Preceptorship (e.g. Morle 1990; Burnard 1990; Ellis 1993; Woodrow 1994), and its use as a pre-registration teaching learning strategy (Bowles 1995) or a post-registration support role (Morton-Cooper and Palmer 1993). The more recent literature addresses the issue of preceptorship in two ways, directly, through small scale research studies and indirectly, through the evaluation of Project 2000 courses. Before exploring this further, a brief review of the literature from USA and Canada, where preceptorship has been widely used since the mid seventies, will be presented.

2.4.1 USA and Canada

The Role of the Preceptor

During the late 1970s and throughout the 1980s an expanding body of literature pertaining to preceptorship emerged. The bulk of this literature was descriptive in nature for example: Ferris (1988); Hitching (1989); Piemme et al (1986); Limon et al (1982). Shamian & Inhaber (1985), Piemme et al (1986), and Lewis (1986) all explored the role of the preceptor and agreed that the preceptor assumes responsibility for guiding, teaching, supporting and evaluating the student's performance. The characteristics of the 'ideal preceptor' were outlined and the importance of communication and interpersonal skills highlighted.

As well as communication and interpersonal skills the importance of clinical competence in preceptorship was well recognised throughout this literature. Ferris (1988) suggested, however, that experienced nurses are usually thrust into teaching situations and acknowledged that being clinically competent does not necessarily make a nurse a competent teacher. More recently Westra and Graziano (1992) recognise that "most preceptors have little or no experience in teaching their nursing colleagues" (p.214). These authors used a questionnaire and five-point Likert scale to compare preceptors' perceived needs prior to, and following, at least one month experience as a preceptor. The questionnaire was distributed to new preceptors prior to a one-day workshop, and following experience in the role. The questionnaire was designed to rate the changes in the preceptors' own learning needs as well as measure any change in opinion regarding what content or preparation was critical for all preceptors to have. The findings identify a statistically significant difference between the perceived needs for evaluating novice performance and for more clinical experience, before and after the workshop and experience. Preceptors themselves

clearly appreciate the importance of sound clinical experience for the preceptor role. While these findings inform courses of preparation for the preceptor's role, they highlight the need for selection for the preceptor role. Myrick and Barret (1994) also addressed the role of the preceptor and highlighted the need for scrutiny in selection and preparation. These authors acknowledged that preceptors are often selected because of their availability rather than ability or qualification. They go on to question whether nurse educators are perpetuating the status quo in nursing by promoting this process.

With the exception of Westra and Graziano (1992), most of the above studies have been descriptive in nature. The trend in the more recent literature is, however, moving from description towards evaluation and measurement of the effect of preceptorship programmes. Ouellet (1993) identifies two broad categories into which the literature falls:

- the effect of preceptorship on clinical competence, and
- the relationship of preceptorship to role socialisation.

Effect of Preceptorship on Clinical Competence

Olsen et al (1984); Scheetz (1989); Clayton et al (1989) and Jairath et al (1991) all examine the effect of preceptorship experience on clinical performance. While Scheetz; Clayton et al and Jairath et al provide evidence indicating positive results Olsen et al did not detect any significant differences between the students who were part of a preceptorship programme over those who were not.

Scheetz (1989) compared clinical competence in 72 senior students undertaking baccalaureate nursing programmes in the eastern United States. Thirty six of the students participated in a summer preceptorship experience and were compared with

thirty six who worked as nursing assistants in non teaching clinical settings. The results showed that students in the preceptorship programme demonstrated significantly greater increases in clinical competencies. While the findings of this study are significant they are not surprising. Most of the participants had chosen a particular work experience because they wanted to improve their clinical competence, clinical experience and self confidence. The subjects in the 'treatment group' had structured preceptor/preceptee relationships and the comparison group worked as nursing assistants in a 'noninstructional' clinical setting.

While those in the treatment group had a formal relationship with a preceptor, those in the comparison group 'developed' a relationship with one or more staff nurses during the experience. However, within the preceptorship group learning outcomes and student objectives were made explicit, the learning experience was structured to meet the student's individual needs and supplementary classroom experiences were designed to supplement their clinical work activity. Therefore while the results are significant in supporting the use of preceptorship, the two groups are not comparable. A more focused study would be required to identify the direct relationship between preceptorship and the development of competence.

Laschinger and McMaster (1992) reported findings from their exploratory study. Using Kolb's (1984) theory of experiential learning as a framework they reported that preceptorship experience had a significant impact on the development of senior students' adaptive competencies (those competencies which enable them to adapt to changing work environments). However, the students involved were in the fourth year of their programme, participating in a twelve week preceptorship in a clinical area of their choice. The extent to which the findings are generalisable is therefore limited. Reflecting on other studies, for example, Ouellet (1993), the length of the

experience may play a significant role in the development of competence. Also, the clinical area being of personal choice, may have an impact on the outcomes.

More recently, Ridley et al (1995) also used Kolb's experiential learning theory as a framework to explore the effect of senior preceptorship on adaptive competencies and learning styles of 55 third year community college students, these were diploma students as opposed to baccalaureate students in the previous study. Questionnaires were distributed prior to and on completion of a preceptorship experience in the final semester of the programme. As well as identifying that the preceptorship experience contributed significantly more to their development of competence than weekly clinical experiences, subjects rated their concrete and abstract competencies and the importance of divergent and convergent competencies significantly higher following the preceptorship. These results support Kolb's (1984) contention that individuals in human service professions demonstrate largely concrete, people orientated learning tendencies. The findings of this study of diploma students are generally consistent with those of other nursing student populations. The authors acknowledge that while the students perceive themselves as possessing strong concrete skills - desirable in nursing as it is a people-orientated, caring profession - profiles of both diploma and baccalaureate nursing students suggest that they are less confident in abstract skills such as leadership.

Preceptorship and Professional Socialisation

Clayton et al (1989) and Jairaith et al (1991) use a quasi-experimental design to determine the effect of preceptorship on the socialisation of students into the role of professional nurses. Clayton et al focused on two groups of baccalaureate students, one having a preceptorship in the final quarter of their programme and the other having a 'traditional' clinical experience. Both groups completed Schwerian's six

dimension scale of nursing performance, the questionnaire consisting of six subscales: leadership, critical care, teaching, planning/evaluation, interpersonal relations/ communications and professional development. Testing was carried out on three occasions: prior to the course, immediately following the course, and six months after graduation. The preceptor group scored higher on five of the six subscales when tested immediately after the experience and significantly higher on four of the six subscales at the six month follow up, as well as on the overall socialisation instrument. This indicated that the increase in professional socialisation continued over time. Interestingly, the subscales which reported higher after the six months included leadership which was considered as a more abstract skill which the students in Ridley et al's study perceived to be lacking.

While Clayton et al focused on baccalaureate students, Jairaith et al used the same instrument in their study of diploma students. Both studies presented positive results relating to role transition from students to professional nurse. However, the findings of Jairaith et al were not consistent with the larger study carried out by Clayton et al in the post program scores of preceptor and nonpreceptored nurses. Jairaith et al suggest the reasons for these differences in outcome are not known, but one reason may reflect the differences in the type of program studied. Although these authors provide some evidence that a preceptorship program promotes behaviours consistent with the professional nursing role and thus facilitates the transition from student to professional nurse, they advise caution when implementing such a system. They identify, in conjunction with related research, that no consistent pattern regarding the effects of preceptorship programs in nursing has emerged and recommend further investigation.

Ouellet (1993) examined the effects of a preceptorship experience on nursing students' perceptions about professional nursing before and after four week and seven week preceptorship experiences. The results showed that while there were no significant differences in students' perceptions after a four week preceptorship experience, a significant difference was found after the seven week experience. There were significant differences in scores between students paired with baccalaureate and those paired with diploma prepared nurses. Ouellet concluded that baccalaureate prepared preceptors provided greater professional socialisation for their students. These findings may be of particular relevance to the present study in which the majority of students, since the recent reforms in nursing education, are paired with preceptors from different educational backgrounds.

Changes in role expectations and self image were measured in a quantitative study by Dobbs (1988). Corwin's Nursing Role Conception Scale was administered to 103 nursing students immediately before and after a clinical preceptorship experience. Findings supported the effectiveness of preceptorship as a method of promoting anticipatory socialisation to the working role of the professional nurse. Students experienced a significant decrease in perceived role deprivation (inability to function immediately as competent professional nurse) and a significant increase in the number of work centred role models. Itano et al (1987), however, using the same measurement tool, compared role conceptions and role deprivation in students participating in a preceptorship programme with those who did not, their results identified no significant difference between the two groups.

Preceptor and Student Views

Other studies which fall into neither of the above categories but add to the growing body of research explore preceptors' and students' views of preceptorship as well as the selection process for preceptors.

Peirce (1991) carried out a qualitative descriptive study to ascertain students' views of their preceptorship experience. Data were collected by anonymous questionnaire rather than interview. Content analysis was carried out from which two overall themes emerged: what students desire from their clinical experience; and the factors that influence the preceptorial experience. In addition differences were found between perceptions of students in the first and last preceptorship experiences, possibly reflecting the difference in professional growth. The limitations of this study lie in the relatively poor response rate, 50%, and the use of questionnaire. Semi structured interviews would have allowed for more in depth information.

Hsieh and Knowles (1990) used participant observation and direct feedback with preceptors, students and instructors to explore the development of the relationship between preceptor and student. They identified seven themes which influenced the outcome of the preceptorship: trust; clearly defined expectations; support system; honest communication; mutual respect and acceptance; encouragement and mutual sharing. These authors highlight the need for further, more in-depth study to understand the many other variables that also influence the relationship.

Support and Reward

Many of the studies reporting on the preceptors' experience tend to focus on the responsibilities within the role, their needs and the resulting benefits. A study by Yonge and Krahn (1991) explored preceptors' perceptions of their role and this was

followed by a more recent survey by Yonge, Krahn, Trojan and Wilson (1995) exploring preceptors' perceptions of support and reward for the role. This later study indicated that both support and reward are crucial to the success of a realistic preceptorship for all members of the triad, the preceptor, student and nurse educator. More recently Usher et al (1999) in Australia, replicated a Canadian study by Dibert and Goldenberg (1995), to explore preceptors' perceptions of benefit, reward and support, as well as their commitment to the preceptor role. A convenience sample of 105 preceptors participated, compared to 59 preceptors in the Canadian study. A four part questionnaire was used to collect data. Correlation approaches were used to analyse data to allow for comparability in results between the two settings. The results, in the main, parallel those of the original research, indicating a clear commitment to the preceptor role when participants perceived there to be both material and non material benefits for acting as a preceptor, the latter considered to be of greater relative importance. While material rewards were not considered of the greatest importance to the preceptors, access to resources for professional development were identified as a means of recognition of the role by the institution. Support from the institution and co-workers was considered vital.

Myrick and Barrett (1994) identify a dearth of research to substantiate many of the benefits of preceptorship, not only to the preceptor, but also the student and the health care consumer. They differentiate between the ideal and the reality when selecting preceptors for students and go on to say: 'frequently the preceptor is selected and paired with the nursing student on the basis of who is available at the time of the clinical placement and not necessarily on the suitability of preceptor for preceptee' (p.196). While addressing the issue of selecting clinical preceptors for students and the impact on the preceptor Myrick and Barrett acknowledge the concerns associated with preceptorship but agree it is an exciting, innovative and

challenging clinical teaching strategy. However, they go on to caution that it is the implementation of preceptorship which determines whether the goals of teaching and learning are achieved.

Given the fact that preceptorship has been established in the USA and Canada for more than two decades, this review of the literature is of value in highlighting the issues surrounding the practice and the experience of the participants. However, findings from these studies cannot be generalised or readily transferred to the UK context. Not only is the organisation and management of nurse education different but also the health care and higher education systems. It is now appropriate to identify and review the relevant UK literature and identify the significance to the present study.

2.4.2 The UK Context

Nurse Education

One of the seminal studies of socialisation in nursing is that by Melia (1981). Melia provides a unique insight into the world of the student nurse in the UK in the 1980's. She used a grounded theory approach to explore the processes involved in learning and working in a traditional nursing course. Since Melia's work, nurse education in the UK has undergone radical reform and students are no longer employed under contract to provide care during their course of preparation, they are supernumerary to service requirements. More recently, and in light of these reforms, a study by Gray (1997) presents a new theory of professional socialisation in relation to Diploma of Higher Education In Nursing Students (Project 2000) in the UK. Her longitudinal study also used a grounded theory approach to explore the effects of supernumerary status and mentorship on students undertaking practice placements. She

acknowledges the confusion surrounding the terms mentor and preceptor and the arbitrary way in which they are implemented. The term mentor is used within the study to describe the person supervising students during periods of clinical practice. The findings indicate that the 'mentor' is the linchpin of the student experience and that the role of the mentor is crucial to the professional socialisation of the student nurse.

Evaluation Studies

Throughout the 1990's a number of studies have been carried out to evaluate the outcome of Project 2000 and the implementation of the Diploma of Higher Education in Nursing and Midwifery. While the focus of these studies is the overall preparation and education of nurses as well as their 'fitness for practice', the relevance to this present thesis lies in the influence of mentorship and preceptorship identified in each.

Early research evaluating Project 2000 identifies the significance of the mentor's role in supporting students and facilitating learning during periods of clinical practice (Jowett et al 1994; White et al 1994). White et al carried out a two stage study using semi-structured interviews and case studies to explore the relationships between teaching, support, supervision and role modelling in clinical areas, within the context of Project 2000 courses. These authors reported widespread uncertainty among practitioners about their role in relation to supporting students and a 'mis-match' of expectations between students, practitioners and tutors. Part of the explanation for this uncertainty was the short timetable for the implementation of Project 2000, a finding supported by Hallett et al (1995) in their study of the implementation of Project 2000 in the community setting. As these studies were carried out in England and focused on the early demonstration districts, the extent to which the findings can be generalised to Scotland is limited. A lengthier preparatory period was established

before implementing the new programmes throughout Scotland. However, both of these studies, White et al and Jowett et al, identified that students undertaking the Common Foundation Programme required very close supervision and support. Conversely, those in the branch programmes valued the opportunity to practice new found skills independently, as long as supervision was available when required. What was clearly evident in both was that what students require from a mentor changes during the course of an educational programme

The national evaluation of project 2000 in Scotland (May et al 1997) identified very different arrangements throughout the country for supporting students' learning in practice placements. Using an illuminative evaluation approach as described by Parlett and Hamilton (1972), they acknowledged the preparation of qualified staff for the role of mentor as a fundamental factor in placement based learning. Preparation for the role varied widely throughout the six case study colleges in the research. Only one college provided a course of preparation which was seen to be adequate by students and mentors alike.

While these studies reported on the implementation of Project 2000 and explored the process of teaching and learning within the Diploma of Higher Education in Nursing, other studies reported on the perceptions of newly qualified staff nurses and more senior nurses on the quality of preparation for the role of staff nurse. Maben and Macleod Clark (1998) explored the transition experience of newly qualified Project 2000 diplomates. A qualitative approach was utilised involving in-depth interactive interviews with 10 staff nurses and constant comparative analysis of the data. The report comments on the now common criticism of Project 2000 courses which suggests a lack of practical skills on completion of the course. However, these authors recognise that for the majority this was an initial issue only and that any

deficits in this area were quickly made up. This finding is validated by earlier studies such as Jowett et al (1994) and Macleod Clark et al (1996). Although this work of Maben and Macleod Clark (1998) was a small scale study it offers indicators for further research to determine the effects of the practice environment on the transition process of newly qualified diplomates, on the effects of a comprehensive preceptorship programme, as well as on the tracking of the skills development of the new staff nurses.

In Scotland similar findings are reported by Runciman et al (1998) who used questionnaire, interviews and focus group strategies, to explore employers' needs and the skills of the newly qualified Project 2000 staff nurses. Runciman et al recognise a striking similarity between their findings and those of Luker et al's (1996) study of Project 2000 diplomates in England. Luker et al employed multiple methods and utilised both quantitative and qualitative approaches to investigate the degree to which managers of the nursing workforce were satisfied with the product of the new nursing educational programme. Runciman et al identified practical skills as well as managerial and organisational skills as the two areas in which the newly qualified nurses needed a considerable amount of help when first qualified. While recognising a number of strengths in the new diplomates, these authors attribute the deficit in practical skills to short clinical placements during the diploma programme. It was suggested that short clinical placements provided limited opportunity for repeated practice with feedback on skill development.

These latter studies are of significance to the present study because they identify the need for greater levels of support in practice. In addition, they contribute to the current political debate on the education and preparation of nurses.

The recent government publication, 'Making a Difference' (DOH 1999) responds to these reports in the comment 'evidence suggests that in recent years students completing training have not been equipped at the point of qualification with the full range of clinical skills they need A stronger practical orientation to pre registration education and training is needed' The report goes on to recognise that provision of clinical placements is a vital part of the education process and 'every practitioner shares responsibility to support and teach the next generation of nurses and midwives ... we want higher quality and longer placements in a genuinely supportive learning environment' (p. 27).

The need for greater learning support in practice is also recognised in the UKCC's recent commission for nursing and midwifery education (UKCC 1999). This report recognises the crucial role of the mentor in facilitating student learning. However it also recognises the inconsistencies in the quality of mentorship provided. One of the major recommendations from the study is that preparation, support and feedback to mentors of pre registration students should be formalised.

Practitioner and Student Experiences of Preceptorship

The most recent British literature, Watson and Harris (1999) and Watson (1999) begins to shed more light on the experiences of both practitioners and students in relation to their respective roles in learning from practice, thus providing some empirical evidence relating to preceptorship.

Watson (1999) carried out a small scale study exploring the students' views of mentorship. She acknowledges the confusion surrounding the concepts and uses the term mentor when describing the functions attributed earlier to preceptorship. A case study approach was used to investigate one pre-registration module within one

organisation. She drew on a phenomenological perspective to study the experience and perceptions of 35 students and 15 mentors. While the findings are not generalisable, due to the sample size and focus, some interesting findings demand further attention. Both mentors and students agreed that, from both perspectives, preparation for the role of mentor was necessary but lacking. They also agreed that learning was facilitated by clinical support and role modelling. However, disagreement was evident in relation to expectations and perceptions of the mentor role. While the students saw planning as a key feature of the mentors' role, the mentors did not identify this as part of their remit. The students expected the mentor to plan a learning menu and ensure a range of appropriate experiences to include visits to other departments and time with other members of staff. Atkins and Williams (1995), who explored registered nurses' experiences of mentoring undergraduate students, and Spouse (1996), whose focus was on the undergraduate students' experience of mentorship, also identified planning as an important aspect of the mentor's role. The limited understanding of the mentor role, as well as lack of coherent preparation and support for mentors supports earlier findings by Cahill (1996).

More recently, Watson and Harris (1999) adopted a mixed method approach to assess the needs of those who support students in practice placements. Their study involved each of the institutions responsible for nursing and midwifery education throughout Scotland thus providing a national picture. Data were gathered from a wide range of sources including students, mentors, lecturers as well as executive nurses and chief executive nurses on NHS trust boards. The findings of the study provide a broad description about the nature of support offered to students in placement as well as identifying factors which impinge on the effectiveness of both the support which is provided, and the preparation of those who provide that support. Students in this

study attached considerable importance to the need for mentors to be aware of their learning needs and to plan accordingly. However, a discrepancy was evident between the student and the mentors' perceptions of the degree to which this was realised. One reason for this discrepancy was attributed to preparation for the role. Those practitioners who attended mentor preparation courses of five days or more were significantly better prepared in all aspects of the role. In relation to the influence of the mentor, these authors found a statistically significant impact on students' learning when at least 50% of the time was spent on the same shift as the mentor. They also acknowledged the influence of the mentors' attitude on student learning which is particularly relevant given that most mentors were required to assume the role rather than volunteer for it. It is subsequently recommended in the report that mentors who are motivated and value learning should be selected and their responsibility in the role should be formally recognised. This is consistent with the findings of Usher et al (1999) in Australia. Watson and Harris also acknowledged the inconsistency in the terms used to describe those who supported students in practice and recommend that the UKCC's terminology of 'mentor' is universally accepted.

Spouse (1996) reports on a longitudinal naturalistic study of eight nursing degree students and acknowledges the mentor relationship as an important aspect of the student's knowledge and growth. She identified 'befriending' within the mentor student relationship to be the key to all other learning activities in clinical practice. Preparation for the role of mentor was, however, essential to the success, a finding supported in other studies such as those by Wright (1990) and Watson (1999). Later papers by Spouse (1998a 1998b), using data from the aforementioned longitudinal study, introduced sociocultural activity theories of human learning to explain the importance of 'sponsorship' and participation in practice. The strength of this work

lies in the use of a sociocultural perspective to explain the influence of learning support systems in the practice of nursing. This theoretical perspective, not previously used in nursing studies, could be explored further to enhance knowledge and understanding of the process of student learning in the context of clinical practice. The limitation of this study by Spouse (1996) rests on the small sample size of degree students whose clinical placements lasted between ten and thirty days except during their second year when the placements were shorter and more numerous. Indeed, much of their clinical practice was one or two days a week and often at the weekends. This would not be reflective of the majority of student placements and generalisability would therefore be limited. Length of placement is a significant factor in the quality of the learning experience as reported earlier in studies such as Watson and Harris (1999).

Factors influencing the experience of preceptorship

Three significant factors persist throughout the literature which influence the experience of preceptorship: the preceptor-student relationship, preparation for the role and the length of the student placement. The attitude of both preceptor and student contributes not only to the relationship but also to the outcome of the experience (Watson and Harris 1999). While each of the above studies identify the need for preparation for the role of preceptor, inconsistency in the length and quality of preceptorship preparation is evident throughout the UK. Watson and Harris (1999) identify that placements of at least five weeks duration have a statistically significantly greater impact on the students' learning than shorter placements. This finding supports those identified in the American studies.

In conclusion

Preceptorship is now widely used within nurse education and while there is an abundance of literature from the USA and Canada there is as yet limited empirical evidence to support its implementation in the UK nurse education system. A growing body of literature clearly identifies the elements of the preceptor's role and the need for preparation for the role. Student and preceptors' experiences are now being analysed and interpreted in studies such as those by Watson and Harris (1999) and Watson (1999). Nonetheless, the processes through which the student nurse learns during clinical practice, and the influence a preceptor has on this process, remains poorly understood. More knowledge is required on how students learn from practice and the way in which a preceptor facilitates this process. The overall aim of preceptorship which is to facilitate student's learning from practice requires further exploration to determine the extent to which this is met.

This review of the nursing literature has aimed to provide a background to the present study. However, as the focus of preceptorship is individualised teaching and learning within the clinical setting, it is now appropriate to provide a selective review of the literature pertaining to learning and the influence of the environment before presenting a theoretical framework within which to locate the study.

2.5 The Learning Environment

The learning environment in nurse education has been extensively explored throughout the past decade. French (1992) in an evaluation of pre-registration preparation of nurses in the 1980's indicated that the clinical setting and the practitioners within were the most influential factors in the development of nurses. This finding was consistent with others such as Benner (1984), Freidson (1985) and Schon (1988). Many studies from both nursing and higher education highlight the importance of the environment in student learning. Knowles (1983) suggests the central dynamic of the learning process is perceived to be the experience of the learner and he defines experience as: 'the interaction between an individual and his environment' (p.68).

Knowles (1983) goes on to describe an ideal learning climate as one which causes the student to feel:

.. accepted, respected and supported in which there exists a spirit of mutuality between teacher and student as joint enquirers, in which there is freedom of expression without fear of punishment and ridicule (p.57).

This description is supported by research in both nursing and higher education. Studies carried out by Ramsden (1979); Ramsden and Entwistle (1981); Entwistle and Tait (1990) and Trigwell and Prosser (1991) in higher education have generally agreed that a learning climate which involves respect for students, freedom to learn and enthusiasm on the part of the teacher encourages a deep approach to learning, while departments with heavy workloads, assessment demands and lack of freedom encourage a surface approach to learning.

While these studies relate to students' experience of higher education a number of studies have explored the clinical learning environment in nurse education (Pembrey 1980; Orton 1981; Fretwell 1982; Ogier 1982). Similar conclusions have been

drawn in that a sound learning climate is identified as one in which there is team work, consideration, empathy and support of the learner as an individual.

Fretwell's (1982) study identified the characteristics of a '*good*' ward learning environment as one in which the sister and staff nurses show interest in the student when they begin on the ward; establish good relationships with the student; are approachable and available; pleasant yet strict; promote good staff patient relationships and focus on quality of care; give support and help to learners; invite questions and give answers; work as a team. Fretwell found that an ideal environment is created by the sister and is characterised by teamwork, negotiation and good communication.

Throughout the nursing research not only is the attitude and behaviour of staff associated with facilitating learning but also the work organisation and approach to patient care. Research by both Alexander (1983) and Reid (1985) identify wards where staff demonstrate an individualised approach to care of their patients as offering a better learning environment for the student nurse. In contrast other aspects of the ward environment have been uncovered which are inconsistent with learning. In particular a system in which tasks are allocated to workers according to their place in the hierarchy is severely criticised, as trained nurses are taken away from learners who are most in need of help. In 1987 Jacka and Lewin found that, on average, students spent half their time on duty working on their own rather than being supervised or paired with a trained nurse. Task allocation was found not only to fragment the care required by patients, but in addition, failed to facilitate meaningful learning in the student. Unless the student understands the relevance of the task and its relation to the total care of the patient it may not be a positive educational experience. More recently Twinn and Davies (1996) recognised the effectiveness of the learning environment in settings where primary nursing had been introduced. Research in higher education has demonstrated that perceptions of learning tasks are partly determined by students' previous experience and failure to perceive relevance has been associated with a surface approach to learning (Marton et al 1984).

Students as Individuals

Students enter nursing courses for a variety of reasons and from a variety of educational and social backgrounds. Reflecting the demands of a changing society and a changing health care system as well as the demographic changes in the number of young adults entering higher education, the cohort of students in nursing courses is much more diverse than that of the 1970's and 1980's. While in the past the majority of new recruits to nursing were more likely to be young females between the ages of seventeen and twenty years, today there are many more mature entrants and many more males. This changing profile of nursing students is reflected in a survey by Smith and Seccombe (1998). The diversity of age group and gender, as well as the different educational backgrounds from which students enter nursing courses, reinforces the need to recognise learners as individuals and take into account differing needs and perceptions not only of nursing but of learning. In short, student nurses are individuals and as individuals are likely to perceive their learning environment in different ways.

Individuals' perceptions of learning have been widely explored and supported in the general education literature. Perry (1970), for example, identifies a sequence of intellectual development stages where students matured from a stage of dualistic thinking in expecting right answers to be presented by the teacher through to the stage of relativistic thinking where the need to make some personal commitment based on careful examination of available evidence is accepted. Students progressed and regressed through the stages in response to intellectual maturation, education and experience. In Perry's view this represented a transition from 'the conception of knowledge as a quantitative accretion of discrete rightness ... to the conception of knowledge as the qualitative assessment of contextual observations and relationships' (Perry 1975 p.145).

The importance of Perry's work lies in recognising the wide range, in any one college year, of the ways in which students understand 'the nature of knowledge, the origin of values, the intentions of instructors and their own responsibilities' (Perry

1970 p.215). Similarly, Saljo (1979) considered that 'how' and 'what' the student learned was to a large extent 'a consequence of his beliefs about what learning is' (p.444). In his study Saljo identified five rather different conceptions of learning which were related to a student's educational background, these were:

- A quantitative increase in knowledge,
- Memorisation,
- The acquisition of facts, methods, etc. which can be retained and used when necessary,
- The abstraction of meaning,
- An interpretative process aimed at understanding reality.

The relevance of this research to the current study should not be overlooked. Reflecting on the work of both Perry and Saljo reminds us that far from being a homogeneous group, students on nursing courses are likely to hold distinctly different conceptions of learning depending on their background and experience. In turn, these different conceptions will influence the way in which an individual student will approach learning, not only in the academic environment but also during clinical practice.

Approaches to learning

Depending on their different conceptions of learning individuals will have different approaches to learning. Here again the research from higher education studies is vitally important in developing understanding of how students go about learning. Marton and Saljo (1976; 1984) established the relationship between conceptions of learning and the way in which an individual approaches an academic task. Two distinctive approaches to learning were yielded and described as deep level and surface level processing. A deep approach is associated with an attempt to understand, building up knowledge, making connections and relating to previous experience whereas with a surface approach connections are not made because the intention is not to understand but to reproduce material. While these studies were

carried out in relation to reading an academic text, the qualitative distinction between deep and surface approach has been observed in relation to essay writing (Hounsell 1984); learning from lectures (Hodgson 1984); and problem solving (Laurillard 1984). One of the potential errors in interpreting these findings is to view the deep or surface approach as a predetermined or fixed characteristic of the individual. Laurillard (1984) suggests that:

.. it is not possible to characterise a student as 'deep', only an approach to a particular academic task. The deep and surface dichotomy describe a relation between the student's perception of a task and his approach to it. The outcome of this perception is 'an intention either to understand or to memorise and thereby to use either a deep or surface approach (p.135).

Not only does the student's perception of learning influence his approach to the learning task but so also does his perception of the environment. Trigwell and Prosser (1991) provide evidence of a relationship between students' approaches to study and their perceptions of the learning environment, findings which are consistent with earlier work of Entwistle and Ramsden (1983) and Entwistle and Tait (1990). Interest and anxiety were other factors which affected a students' approach to learning. Entwistle (1988) explained this further:

it was not so much that anxiety provoking situations induced a surface approach to learning, but that students who felt the situation to be threatening, whether that was intended or not, were more likely to adopt a surface approach. This mechanical, rote learning approach was also related to lack of interest .. (p.82).

Again, although these studies relate mainly to academic environments it is clear that it is the environment as perceived by the student, not necessarily the objective environment, which relates to approaches to learning (Trigwell and Prosser 1991). While the context of these studies has been academic environments, it is argued here that the findings are equally relevant to the clinical learning environment and the student nurses' perception of that environment. Understanding of student approaches to learning can influence the development of appropriate strategies in learning from practice.

The value of this research to the current study lies in the suggestion that the quality of learning outcomes is dependent on the approach that the student adopts. In turn it would appear that the student adopts an approach that is determined by the subtle interaction of the learning context and the student's perception of that context. The student who is anxious and feeling threatened within an environment is more likely to adopt surface strategies in their approach to learning. It is therefore important for the student to feel comfortable within an environment so that they can focus on adopting a deep approach to learning. This is expressed by Trigwell and Prosser (1991) in:

Improving the quality of learning outcomes may result from the establishment of an academic environment which encourages deep learning .. students who have higher quality learning outcomes have adopted deeper and/or more relating approaches to learning. The environment as evaluated or perceived by those students is one in which the lecturer gives adequate and helpful feedback, makes clear the objectives, the assessment criteria and generally what is expected of the student .. (p.263)

In Conclusion

To promote learning the impact of the environment must be recognised. We are therefore challenged to provide a clinical environment in which students experience respect, acceptance, freedom and comfort, in short one in which they feel 'free to learn'. Only then can students of nursing focus on developing knowledge and understanding of patient care as well as learning to learn from and through experience.

This literature clearly identifies the influence of the environment and the people within the environment, on the students' approach to learning. Throughout the nursing literature role modelling was often drawn on as a means of explaining how students learn in practice and was clearly identified as a central feature of preceptorship. It is therefore appropriate to explore the literature on role modelling and social learning theory further before identifying and selecting an appropriate theoretical framework for this study.

2.6 Role Modelling

The primary aim of Preceptorship in nursing is to facilitate learning and role modelling is identified as a central feature of the practice (Chickerella and Lutz 1981). Role modelling has long been recognised as one of the most powerful ways in which learning occurs in the clinical setting (Howie 1988, Ogier 1989, Davies 1993). If it is accepted that much of students' clinical learning occurs through observation of role models then it would seem essential to develop an understanding of how this learning occurs. In the context of nurse education Perry (1988) utilised a social learning theory framework to offer insight into the mechanism of how and why nursing students learn from preceptors articulating the urgent need to improve students' learning experiences in the clinical setting.

Social Learning Theory (Bandura 1977)

In the 1960s and 1970s Bandura developed a "Cognitive Mediation Theory of Observational Learning". This theory is based on the reasoning that learning takes place during the process of observation without any overt activity on the part of the observer, thus he suggests, learning must be due to some covert behaviour, namely the thought process of the observer. Bandura differentiates between imitation and modelling when he said:

the difference between observational learning and imitation is the difference between learning and performing

Dulany and O'Connell (1963) cited in Bandura suggest that in the course of learning, people not only perform responses but also notice the effects they produce. By observing the different outcomes of their actions, they develop hypotheses about which responses are most appropriate in which settings. Thus acquired information then serves as a guide for further action. Accurate hypotheses give rise to successful

performance, whereas erroneous ones lead to ineffective courses of action. Through this process cognitions are selectively strengthened or disconfirmed by the differential consequences accompanying the more remotely occurring responses. Bandura goes on to assert that contrary to the mechanistic view, outcomes change behaviours in humans largely through the intervening influence of thought (Bandura 1977 p.18).

What Do We Learn From Role Models?

Bandura (1977) suggests people learn among other things judgmental orientations, linguistic styles, conceptual schemes, information processing strategies, cognitive operations and standards of conduct. However, as well as these cognitive and behavioural factors he argues that emotional and moral responses can also be learned in this way.

Models generally express emotional reactions while undergoing rewarding or punishing experiences . . . Fears and inhibitions can be reduced as well as acquired through the observation of response consequences (p.126)

Within the context of nursing many authors have highlighted the influence of role modelling on the socialisation process, Betz (1985), Howie (1988), Melia (1987), Ogier (1989). However, in spite of the potential and expressed power of role modelling in professional socialisation there is a dearth of empirical research in the contemporary nursing literature to explore this phenomenon.

A recent study by Campbell et al (1994) examining student socialisation into nursing suggested that clinical instructors who were identified as outstanding role models were viewed as the major vehicles for the transmission of knowledge to student nurses. Considering the potential power of the role model in clinical situations it is

important to explore what knowledge is transmitted in this way and address the question: *what do students learn from role models?*

Wilson and Startup (1991) remind us that the image of the 'good nurse' is built through personal observation of divergent practice and reconciliation of conflicting philosophies. Howie (1988) advises caution regarding the interpretation of studies based on student perceptions and suggests the behaviour of role models is likely to be interpreted in the light of past learning experience and personal objectives. This is consistent with the work of Dotan et al (1986) who highlight the change in students' perceptions of good role models depending on their own degree of professional development. In the early professional life stages the personality of the role model is likely to gain the students' attention. With reference to Kemper (1968) Dotan et al suggests that in learning from a role model individuals will concentrate on those skills and techniques that they themselves lack.

Using Bandura's framework, while modelling is a very important element of the learning process, it is also potentially concerning as the novice student lacking experience will be less discerning in terms of identifying professional competence and the behaviours he/she will focus upon. In the more advanced student personality becomes less important while knowledge and skill of the model assumes greater importance. Callery (1990) discusses moral learning in nursing and suggests that social learning theory does not discriminate between desirable and undesirable learning, the role model is a learning tool whether of excellence or otherwise. Nonetheless, he goes on to identify the advantages to nursing education which lie in its focus on the social aspects of learning and its acknowledgement of the complexity of the interaction between the environment and the person. The disadvantages, however, lie in the same complexity of interaction and in social learning theory's

failure to account for the origin of private opinions which are not socially acceptable (Callery 1990 p. 327).

Infante et al (1989) in examining preceptorship as a model for clinical teaching concluded that providing opportunities for students to work closely with role models will result in the acquisition of a realistic understanding of the skills and demands required within the work environment. More recently, Davies (1993) used a grounded theory approach to address the research question "*Does the observation of clinical role models lead students to discover knowledge embedded in clinical practice?*" This was a small scale study involving only six students chosen to participate because they had previously demonstrated their ability to articulate their experiences from an analytical perspective. Interviews were conducted following three one week blocks of clinical practice experience programmed in the first year of the course. The data were analysed using thematic analysis. The study concluded that the knowledge discovered through the observation of clinical role models relates to the artistic rather than the scientific aspect of nursing knowledge, to what is done and in how it is done, rather than the theoretical underpinning for action.

This study by Davies clearly acknowledges the influence of the interpersonal aspects of a role model's behaviour on student learning. In particular the individual's interaction with clients, students and the health care team is highlighted. These interpersonal interactions encompass the values associated with practice and were broadly classified by students as 'good' and 'bad' i.e. they were able to articulate those attributes of nurses which lead to holistic care and those which lead to rigid, fragmented and impersonal care. While the results of this study are of interest, value may be limited primarily because of the very small sample size and also because of the sample choice. Is this small group of articulate analytical individuals typical of

the overall student group? Can their experience be generalised? A further large scale study would be required.

In summary, it can be concluded from the literature that students do learn from observing role models in practice areas. This is supported by the underpinning social learning theory of Bandura (1977) who states "It is hard to say what proportion of human learning is due to direct experience and what proportion is due to observation", however he reminds us that much of our learning involves observation of other people's behaviour and its outcomes. It is not surprising though that in the clinical situation students identify the good nurse as one who demonstrates caring, shows respect for others, has a positive attitude towards work and service and has a high level of ability (Davies et al 1993), the outcome of these positive attributes is reflected in client care.

Bandura viewed learning as the result of interaction between humans and their environment. The significance to this present study lies in the focus on the social aspects of learning, appropriate given that preceptorship is based on a relationship between an experienced nurse and a student in the social environment of clinical practice. Bandura's 'social learning theory' was therefore considered at the beginning of the study as a theoretical framework in which to locate and explain the data. However, following early analysis of the data the complexity of the student learning experience emerged and led to a 'watershed'. During this 'watershed' experience the limitation of a social learning theoretical framework became evident. These limitations will be explained as the thesis develops. Moreover, the early data analysis led to a review of the 'sociocultural' theories of learning which consequently provided the framework within which the data were located, analysed and explained. Having presented a selective review of related literature from both nursing and

education, the following section will introduce the sociocultural theories of learning. This will complete the literature review, setting the scene for the subsequent chapters: the research approach; the findings; interpretive discussion; and recommendations.

CHAPTER 3

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

A theoretical framework is necessary to provide a structure within which to locate and analyse the data. As indicated in the previous section, Bandura's social learning theory was considered at the beginning of the study. The limitation of this particular theoretical framework, however, began to emerge from early analysis of the data which identified the complexity of the student learning experience when working alongside more experienced practitioners in a variety of clinical placements. The early analysis was identifying a need for literature concerned with how interpersonal processes affect the nature and quality of learning, and literature which would inform the learning embedded within particular social and cultural contexts. The study was therefore guided to explore the sociocultural perspectives on learning and development. An overview of this literature will now be introduced to provide a theoretical base which will be drawn upon and related in the interpretive discussion.

The recent work of Rogoff (1990/19993) as well as that of Lave and Wenger (1991) rely heavily on the seminal work of Lev Vygotsky (1934) in arguing that everyday human learning is a context dependent and socially mediated activity. Lave and Wenger argue that learning is integrated with practice and through engagement in a community of practitioners, students (or newcomers) become increasingly competent in their identity as practitioners. This view of learning as inextricably bound with practice is consistent with the views of Vygotsky and Rogoff in the premise that meaning, understanding and learning are all defined relative to action contexts, not to self contained structures. The aim of this chapter is therefore to outline the sociocultural perspective on learning. The seminal work of Vygotsky will be introduced to provide a framework within which the theories of Rogoff as well as

Lave and Wenger can be explored. The relevance to the current thesis and subsequent interpretation of student experience of preceptorship will be explained throughout.

3.2 Vygotsky

Vygotsky (1978) suggests that analysis of ontogenesis, individual development over the lifespan, of cognitive functioning requires studying how children's social interaction with more experienced members of their culture is mastered and internalised. He introduced a 'sociocultural' or 'sociohistorical' theory to explain cultural development and three basic themes run through his writings:

- reliance on genetic or developmental analysis
- the claim that higher mental functioning in the individual derives from social life
- the claim that human action, on both the social and individual planes, is mediated by signs and tools

Vygotsky proposes that any higher psychological function appears twice or on two planes. First it appears on the social plane and then on the psychological plane: first between people as an interpersonal category and then within the individual as an intrapsychological category (Vygotsky 1978 p.57). In Vygotsky's view individual development is a fusion of both physical and cultural growth, taking place on these two planes, hence social and cognitive learning influences maturation and is facilitated by social contact. From the sociohistorical perspective, the basic unit of analysis is therefore not (the properties of) the individual, but (the processes of) the sociocultural activity (Rogoff 1990).

Investigating developmental processes Vygotsky stresses the relationship between social interactive and higher mental processes identifying the linguistic mediation of both kinds of processes. Central to this relationship is the multifunctionality of language and speech as a mediating tool used to attach meaning to objects and

situations. According to Vygotsky society provides 'a tool kit of concepts, ideas and theories' that permit one to get to higher ground mentally.

The new higher concepts in turn transform the meaning of the lower. The adolescent who has mastered algebraic concepts has gained a vantage point from which he sees arithmetic concepts in a broader perspective

(Bruner 1985, p. 23).

These higher concepts provide the means for reflecting on one's own thinking.

Crucial to Vygotsky's position is the claim that higher mental functions are qualitatively distinct from, and hence irreducible to, their primitive antecedents. This is so he argues because higher mental functions represent mediated form of psychological activity (Bakhurst 1990)

In essence, Vygotsky's theories are concerned with the social origins of human development, and learning is the role of social action and interaction. Based on these theories, that learning occurs through social action and interaction, then Vygotsky's work may assist in understanding the influence of preceptorship on the process of student learning in the social context of clinical practice. Rogoff (1990) also reminds us that:

Social interaction of children with more competent members of their society is essential to cognitive development (p.36).

In the context of the present study the student is assigned to and works with a preceptor, who is normally a staff nurse and deemed to be a competent member of the nursing team. The question arises, to what extent does the social interaction with the preceptor influence cognitive development in the student nurse?

Vygotsky focused on our ability to create elaborate symbolic systems, such as natural language and mathematics which mediate our relation to the world through the power of representation. For Vygotsky, a sign is a symbol with a definite meaning that has evolved in the history of a culture. The introduction of such semiotic systems of mediation, according to Vygotsky: 'transforms our psychological relation with reality, we now stand in relation not just to a physical world but to an interpreted world, an environment conceived as being of a certain kind' (Bakhurst 1990).

Vygotsky argues that systems of mediation which form the fundamental basis of human mental functioning are cultural creations, they are products of social history and are preserved in human activity, in the 'interpretative practices' of the community. The development of a child's higher mental functions must therefore be seen as the consequence of appropriation or '*internalisation*' of interpretative practices of the community (Vygotsky 1978).

If we accept Vygotsky's argument and the impact of social history on human mental functioning, then it is important to consider systems of mediation further. Those systems of mediation preserved in the 'interpretative practices' of nursing can then be explored and their potential influence on the cognitive development of the student nurse identified.

Thought and Speech

Fundamental to Vygotsky's theory is the interpretation of thought and speech as instruments for the planning and carrying out of action,

children solve tasks with the help of their speech, as well as with their eyes and hands. This unity of perception, speech and action, which ultimately produces internalisation of the visual field, constitutes the central subject matter for any analysis of the origin of uniquely human forms of behaviour
(Vygotsky 1978 p.26).

Vygotsky identifies two forms of speech, *interpersonal* speech and *intrapersonal* speech. *Interpersonal* speech, otherwise referred to as external social speech, is that used in verbal communication with others. *Intrapersonal* speech is internal speech, which Vygotsky argues, clearly reflects its social origins and promotes higher mental functions such as problem framing and solving.

The acquisition of language can provide a paradigm for the entire problem of the relation between learning and development. Language arises initially as a means of communication between the child and the people in his environment. Only subsequently, upon conversion to internal speech, does it organise the child's thought, that is, becomes an internal mental function
(Vygotsky 1978 p.89).

According to Bruner (1985), Vygotsky notes that at first language and action are fused and it is for this reason that the child talks to himself while carrying out a task. Eventually language and action become separated and the latter (task) can be represented in the medium of the former (words). It is when this stage is reached that one can incorporate what one knows into words and thereby into the process of dialogue (p.30).

In relation to development, language mediates two well differentiated but constantly interrelated spheres of activity for the adult: speech can be used to communicate and establish or maintain social relationships among members of a culture; speech also becomes the primordial sign system that mediates the internal thought processes of individuals, the structuring of their conceptual and reasoning activities, and generally their reflective abilities (Hickman 1985).

Bruner (1985) acknowledges that language, in Vygotsky's sense as in Dewey's, is a way of sorting out one's thoughts about things. Thought and speech are interpreted as instruments for the planning and carrying out of action (Bruner 1985 p.23). According to Shotter (1993a) the interrelation between thought and language, central to Vygotsky's work, includes the sensory, sensuous or affective function of words to move people to perceive and act in different ways (p.132). Vygotsky reminds us that:

when we approach the interrelation between thought and language .. the first question that arises is that of intellect and affect .. if they are separated the door is closed to the issue of causation and origin of our thoughts and we are unable to understand the motive forces that direct thought into this or that channel (Vygotsky 1986 p.10).

Shotter (1993a) suggests that the approach Vygotsky adopts 'shows that every idea contains a transmuted affective attitude towards that bit of reality to which it refers' (p.132). He goes on to say that if we accept that all higher functions originate as actual relations between human individuals then we can claim that the affective

attitude which provides the thoughts and ideas of an individual with their dynamic, is a transmuted version of a social relationship.

The social relation referred to by Shotter (1993a) is described as 'instructional' .. '*we come to instruct ourselves as others instruct us*'. He reminds us of the nature of 'instructive' talk:

People point things out to us (look at this); change our perspective (look at it like this); order our actions (look at the model first, then at the puzzle pieces); shape our actions (turn it over and then it will fit); remind us (think of what you did the last time, what do you already know that is relevant) encourage us (try again); restrain us (don't be too hasty); evaluate for us (that's right, don't do that); set our goals (try to do this before you do that) count (how many will it take); make us check our description (is that right, who else said so, what makes you think that). In doing so these instructions are always voiced in a certain tone, a tone that is shaped among other things by how they see themselves in relation to whom they are addressing. Sometimes explicit evaluations are uttered, they distance themselves (don't do that it's crazy) or they affirm they share our world (wow that's great) (p. 132/3)

Shotter (1993b) claims that the mental processes '*within*' us are similar to the transactions we conduct '*between*' us. Rather than functioning mechanically and systematically, they reflect in their functioning essentially the same ethical and rhetorical (responsive) considerations influencing the transactions between people (p.62).

The relevance of Shotter's work to the current thesis lies in the analysis of the social relationship. The development of a relationship which is instructional in nature, as described by Shotter, is required in preceptorship. It is anticipated that the student and preceptor may develop such a relationship in the context of clinical practice. Notwithstanding the spoken word, the interaction and the intonation within the unequal power relationship of preceptor and student, could determine to some extent the nature of and quality of learning. Not only could it be specific knowledge and skill that is transmitted, but also underpinning attitudes and values towards the particular reality. The data is examined to explore indications of the instructional

relationship and identify the extent to which Shotter's work is relevant to, and supported in, the context of nursing.

Internalisation

Cognitive development relies heavily on the key concept of *internalisation* according to Vygotsky. Wertsch and Stone (1985) define internalisation as: 'the transformation of external activity into internal activity' (p.162). The complexity of the concept is however recognised by Leont'ev (1981) in: 'the process of internalisation is not the transferral of an external activity to a pre-existing, internal 'plane of consciousness', it is the process in which this plane is formed'. Brown and Ferrara (1985) extend this discussion and refer to Vygotsky's argument that:

All higher psychological processes are originally social processes, shared between people, particularly between children and adults. (p.281)

They go on to explain that in early child development the adult's speech controls and directs the child's behaviour. Later, the child's overt (external) speech becomes an effective regulator of the behaviour and as the child develops further, their own covert (inner) speech assumes a regulatory role. The child therefore first experiences active problem solving activities in the presence of others but gradually comes to perform these functions independently. The process of *internalisation* is gradual; first the adult or knowledgeable peer controls and guides the activity, but gradually the adult and the child come to share the problem-solving functions, with the child taking initiative and the adult correcting and guiding when she falters. Finally the adult cedes control to the child and functions primarily as a supportive audience (Brown and Ferrara 1985).

The term 'internalisation' is also questioned by Rogoff (1995) who introduces the terms 'appropriation' and 'participatory appropriation' to discuss how children develop from their involvement in sociocultural activity:

Rather than viewing the process as one of internalisation in which something static is taken across a boundary from the external to the internal, I see children's active participation itself as being the process by which they gain facility in an activity ... The process is the product .. (p. 151)

The purpose of Rogoff's emphasis on appropriation rather than internalisation is to distinguish between two theoretical perspectives:

The appropriation perspective views development as a dynamic, active, mutual process involved in peoples' participation in cultural activities; the internalisation perspective views development in terms of a static, bounded 'acquisition' or 'transmission' of pieces of knowledge either by internal construction or by the internalisation of external pieces of knowledge (p. 153)

Explaining this distinction, Rogoff suggests translations of Vygotsky often refer to internalisation, but his concept may be similar to her notion of appropriation, 'at least in emphasising the inherent transformation involved in the process' (Rogoff 1995, p. 152). In developing her theory of cognitive development in children, which will be addressed further (p.62), Rogoff acknowledged the influence of Vygotsky and 'the zone of proximal development'

3.3 Zone of Proximal Development

Vygotsky's concept of the **Zone of Proximal Development (ZPD)** was an account of how the more competent assist the young and the less competent to reach that higher ground, ground from which to reflect more abstractly about the nature of things. This concept explains how child development proceeds through participation in activities slightly beyond their competence (in their zone of proximal development) with the assistance of adults or more skilled children. The zone of proximal development is defined as:

the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers (Vygotsky 1978 p.86).

Rogoff (1990) explains that the ZPD is therefore a dynamic region of sensitivity to learning the skills of a culture, in which children develop through participation in problem solving with more experienced members of the culture. While the work of Rogoff focuses on infancy and childhood she acknowledges that development is assumed to proceed throughout the life span: 'with individuals' ways of thinking reorganising with successive advances in reaching and contributing to the understanding, skills, and perspectives of their community' (Rogoff 1990, p.11). Examples of reorganisation of thinking in adulthood include managing new roles; taking on new intellectual challenges; career changes where transformation in levels of understanding can be seen; and achieving shifts in perspective where whole patterns of relationships fall into place. Each of these examples reflect the leap of understanding demanded from the novice practitioner in nursing.

Cole (1985) acknowledges the diagnostic and experimental work which demonstrates the ways in which more capable participants structure interactions so that novices (children) can participate in activities that they are not themselves capable of. With repeated practice, children gradually increase their relative responsibility until they can manage the adult role.

Introducing the ZPD Vygotsky proposes, 'the only good learning is that which is in advance of development'. Bruner (1990) however highlights a contradiction in this proposal: On the one hand the ZPD has to do with achieving '*consciousness and control*', but consciousness and control come only after one has already got a function mastered. So how could good learning be that which is in advance of development? .. Bruner goes on to articulate his interpretation as ..

if the child is enabled to advance by being under the tutelage of an adult or a more competent peer, then the tutor or the peer serves as a vicarious form of consciousness until such times as the learner is able to master his own action through his own consciousness and control. When the child achieves that conscious control over a new function or conceptual system, it is then that he is able to use it as a tool. Up until that point, the tutor in effect performs the critical function of scaffolding the learning task to make it possible for the

child in Vygotsky's word, to internalise external knowledge and convert it into a tool for conscious control (Bruner 1985 p.25).

3.4 Scaffolding

Wood, Bruner and Ross (1975) discuss the process of 'scaffolding', which enables a child or novice to solve a problem or carry out a task which would be beyond his unassisted efforts. This scaffolding consists essentially of the adult 'controlling' those elements of the task that are initially beyond the learner's capacity, thus permitting him to concentrate upon and complete only those elements that are within his range of competence. This may result in the development of task competence by the learner at a pace that would far outstrip his unassisted effort.

In the context of preceptorship, the process of scaffolding may be used by the preceptor to allow the student to be involved in care-delivery. The preceptor could 'control' those aspects of the activity which are beyond the student's capacity allowing him or her to concentrate upon and complete those elements which are within the range of competence. In this way the student would be enabled to carry out tasks, either alone or alongside the preceptor, which would be beyond his or her unassisted efforts.

Wood et al (1975), however, advise that the learner cannot benefit from such assistance unless one paramount condition is fulfilled .. *Comprehension* of the solution must precede production i.e. the learner must be able to recognise a solution before he is able to produce the steps leading to it without assistance. Without comprehension there can be no effective feedback.

Bruner explains this further in:

the tutor's general task is that of scaffolding - reducing the number of degrees of freedom that the child must manage in the task. She does it by segmenting the task and ritualising it, creating a format, a nanocosm .. she sees to it that

the child does only what he can do and she fills in the rest. She limits the complexity of the task to the level that the child can just manage, even to the point of shielding his limited attention from distracters' (Bruner 1985, p.29).

Bruner goes on to recall what Vygotsky said about leading the child on ahead of his development and suggests this is done with some prudence from the tutor. Once the child has mastered some routine that was modular to the task the tutor then tempted him to use his skill in a higher order aspect:

As Vygotsky said it is a matter of using whatever one has learned before to get to higher ground next. What is obvious and perhaps 'given' in this account is there must need be at any given stage of voyaging into the Zone of Proximal Development a support system that helps learners get there
(Bruner 1985 p.32)

Tutors must therefore be seen as partners in advancement according to Bruner (1985). This is of course relevant to the present study where preceptorship is a learning support system, and individual preceptors have the potential to influence a student nurse's learning experience. Moreover, to reach this potential, or to be a partner in advancement, the preceptor would require knowledge and understanding of student learning processes. The earlier literature review, however, highlights the lack of preparation for this aspect of the nurses role. The data is therefore explored for indication of the extent to which the preceptor influences learning and development.

Reflection

Bruner (1985) draws on Vygotsky's 'zone of proximal development' and uses the process of scaffolding to explain the manner in which the environment can be arranged to help a child reach higher or more abstract ground from which to reflect, ground on which he is enabled to be more conscious. Using the work of Vygotsky he suggests that prior to the development of self-directed, conscious control, action is a more direct or less mediated response to the world. 'Consciousness or reflection is a way of keeping mind from shooting from the hip' (Bruner 1986 p.73). Bruner (1985) identifies that consciousness or reflection is a way of buffering immediate response so that the situation can be better appraised from higher ground. Rogoff

(1990) also identifies a parallel between reflection, when recognised as internal dialogue, and Vygotsky's chief principle that higher mental functions are internalised from social interactions.

It would appear that reflection is at the centre of some of the most prominent theories of learning, for example: Friere (1972); Argyris and Schon (1974); Mezirow (1981); Kolb (1984); Boud et al (1985) and Jarvis (1987). Mezirow, in fact, identifies seven levels of reflectivity ranging from an initial awareness of perception, to a position of theoretical reflectivity where critical thinking and subsequent perspective transformation takes place. The contemporary nursing literature is also replete with reference to reflection and to reflective practice. Recent empirical studies demonstrate that the nursing profession has embraced reflection as a teaching and learning method for example, Durgahee (1996; 1998); Wong et al (1995); Johns (1996); Mountford & Rogers (1996). While many studies consider reflection as an individual learning strategy, others now highlight the influence of collaboration on learning. Durgahee (1998) discusses collaboration in reflection and suggests:

Learning is maximised when it is shared .. it is more enriching to have others in the process. It enables comparison and testing of perspectives which contributes to the process of clarification and analysis, grounding issues in different contexts .. (p.163).

In the context of the current thesis, and the collaborative nature of preceptorship, it is anticipated that dialogue between the preceptor and student will encourage reflective activity. In Bruner's terms, it may be that the preceptor could be the student's partner in advancement. The need for a support system to help learners advance within their individual 'zone of proximal development' is explicit in the foregoing discussion. The role of the 'tutor' is paramount in maximising progression and development.

The implications for nurse education begin to emerge. Is it possible to arrange the clinical learning experience in such a way that facilitates the student nurse's journey to reach higher ground from which to reflect? Could it be that preceptorship

provides a support system to guide the students through the 'zone of proximal development'? Bruner suggests that Vygotsky's basic belief was that social transaction is the fundamental vehicle of education and not solo performance.

I believe that it was his eventual hope to delineate the transactional nature of learning, particularly since learning for him involved entry into a culture via induction by more skilled members' (Bruner 1985 p.25.)

Given the complex environment of nursing it is essential to explore the interaction of practitioners in context to assist understanding of the process of student learning in practice. The sociocultural influences on cognitive development and learning can then be identified. Having outlined the seminal work of Vygotsky, the more recent work of Lave and Wenger (1991) and Rogoff (1990/1993) will now be introduced. These authors extend the work of Vygotsky, they focus on the community of practice and identify specific influences on learning and development.

3.5 Situated Learning

The work of Vygotsky identifies the process of learning as active and interactive, taking into consideration the social and cultural influences on development. Lave and Wenger (1991) acknowledge Vygotsky's work, particularly the zone of proximal development, and extend the study of learning beyond the context of pedagogical structuring. They place more emphasis on connecting issues of sociocultural transformation with the changing relations between newcomers and old timers in the context of a changing shared practice. In contrast with the view of learning as internalisation, they identify learning as a situated activity, where increasing participation in communities of practice concerns the whole person acting in the world (p.49). A community of practice is seen as 'a set of relations among persons, activity, and the world, over time and in relation with other tangential and overlapping communities of practice' (p.98). They suggest that a community of practice is an intrinsic condition for the existence of knowledge, not least because it provides the interpretative support necessary for making sense of its heritage.

Participation in the cultural practice in which knowledge exists is an epistemological principle of learning and the social structure of the practice, its power relations, and its conditions for legitimacy define possibilities for learning (Lave and Wenger 1991).

3.6 Legitimate Peripheral Participation

Legitimate peripheral participation is the central concept in the work of Lave and Wenger (1991). They argue that learning can only take place when individuals are sponsored into an unfamiliar community of practice by an experienced practitioner and inducted to its everyday (informal) knowledge and practices through 'legitimate peripheral participation'. This is seen as a threefold strategy that:

- enables newcomers to enter the world of old-timers and
- engage in progressive and increasingly complex activities whilst also
- developing identity as a member of the community

Legitimate peripheral participation denotes:

the particular mode of engagement of a learner who participates in the actual practice of an expert, but only to a limited degree and with limited responsibility for the ultimate product as a whole (p14).

Lave and Wenger (1991) propose the concept as a descriptor of engagement in social practices that entails learning as an integral constituent (p.35). '*Legitimacy*' is a defining characteristic of ways of belonging and therefore a crucial condition for learning. These authors suggest that legitimate peripherality provides newcomers with more than an 'observational' lookout post. It crucially involves participation as a way of learning '*of both absorbing and being absorbed in the culture of practice*'. They go on to identify the importance of language, clarifying the difference between talking about a practice from outside and talking within it:

Talking within itself includes both talking within, e.g. exchanging information necessary to the progress of ongoing activities, and talking about, e.g. stories. Inside the shared practice, both forms of talk fulfils specific functions: engaging, focusing, and shifting attention, bringing about co-ordination, supporting communal forms of memory and reflection, and signalling membership (p.109).

Legitimate peripheral participation in such linguistic practice is seen as a form of learning. For newcomers the purpose is not to learn *from* talk as a substitute for legitimate peripheral participation; it is to learn *to* talk as a key to legitimate peripheral participation (Lave & Wenger 1991). Legitimate peripheral participation may therefore serve as a useful framework for exploring access to cultural knowledge, as well as entry into the community of practice in nursing per se. However, the extent to which this informs the process of cognitive development of students in practice is limited. In order to explore the process of cognitive development further, the work of Rogoff (1990/1993) and the process of 'guided participation' is of value.

3.7 Guided Participation

The concept of community which clearly underlies the notion of legitimate peripheral participation is also central to and extended in the work of Rogoff (1990/1993). Rogoff (1993) uses the term 'community' or 'cultural community' to describe a group of people having some common local organisation, values and practice. With reference to Dewey (1916) she reminds us that there is more than a verbal tie between the words common, community and communication, people live in a community by virtue of the things which they have in common and communication is the way in which they come to possess things in common (Rogoff 1993). Children's development is seen as a creative process of participation in communication and shared endeavours that both derives from and revises community traditions and practices.

Cultural tools and practices are both inherited and transformed by new members .. culture itself is not static, it is formed from the efforts of people working together, using and adapting tools provided by predecessors and in the process creating new ones (Rogoff et al 1993 p.6).

Rogoff has developed the concept of 'guided participation' as a perspective to explain how children's development occurs through active participation in cultural systems of practice. In such a system children, together with their caregivers and companions, learn and extend the skills, values and knowledge of their community. Rogoff considers children as apprentices in thinking, active in their efforts to learn from observing and participating with peers and more skilled members of their society.

In Rogoff's work development is considered as

occurring through their active participation in culturally structured activity with the guidance, support and challenge of companions who vary in skill and status (Rogoff et al 1993).

Rogoff (1995) utilises an approach which involves observing development on three planes of analysis: personal, interpersonal and community processes. She refers to the developmental processes corresponding with these three planes as: apprenticeship; guided participation and participatory appropriation. These are seen as inseparable, mutually constituting planes, any one of which can be the focus of analysis at a particular time but with the others necessarily remaining in the background of the analysis.

Apprenticeship is used as a metaphor to provide a model of the community activity where individuals are actively involved, participating with others in culturally organised activity. Part of the purpose is the development of mature participation in the activity by the less experienced.

The idea of apprenticeship necessarily focuses attention on the specific nature of the activity involved, as well as its relation to practices and institutions of

the community in which it occurs - economic, political, spiritual, and material (p.142)

Guided participation refers to the interpersonal processes, the involvement between people as they communicate, co-ordinate efforts, and participate in culturally valued activity. The 'guidance' involves the direction offered by social values as well as social partners. The 'participation' refers to observation as well as hands on involvement in the activity.

Participatory appropriation corresponds with the personal processes, how individuals change through their involvement in the cultural activities, becoming prepared for their involvement in related activities. Rogoff (1995) summarises this in:

With guided participation as the interpersonal process through which people are involved in sociocultural activity, participatory appropriation is the personal process by which, through engagement in an activity, individuals change and handle a later situation in ways prepared by their own participation in the previous situation. This is a process of becoming, rather than acquisition .. (p.142).

Facilitating Learning

In developing the perspective of guided participation Rogoff (1990) acknowledges the influence of Vygotsky. She extends the concept of the zone of proximal development by stressing the interrelatedness of roles and the importance of tacit as well as explicit face to face social interaction in guided participation:

the rapid development of young children into skilled participants in society is accomplished through routine often tacit, guided participation in ongoing cultural activities as they observe and participate with others in culturally organised practices (p.16).

Recognition of the tacit as well as face to face interaction is relevant in the context of this current thesis. In everyday care-delivery nurses often use a form of knowledge they cannot bring to mind, they are often unaware not only of the knowledge they are using but also transmitting to students. Students are learning through collaboration

in practice often unaware of the extent to which they are learning. The tacit nature of knowledge is well recognised in the seminal work of Polanyi (1967). In the context of nursing Clinton (1998) suggests that '*to know something tacitly is to know more than one can tell*' (p.198). Analysis of the student experience must explore and identify the tacit as well as explicit processes of learning in practice.

In Rogoff's work the tacit manner in which adults often facilitate learning is recognised through the selection of appropriate tasks; regulating difficulty; and segmenting tasks into manageable subgoals depending on a child's current state of understanding. The adult also models mature performance during joint participation in activities. Providing access to these activities is instrumental in children's learning although adults seldom regard this role as instructional.

Since development may occur over the course of a single session, the division of responsibility changes during the interaction. Rogoff and Wertsch (1984) explain this in:

Initially the adult may take responsibility for structuring the task and managing progress toward the goal, but the adult must also assure the appropriate transfer of responsibility to the child for managing the activity. This requires sensitivity to the child's level of competence in the particular task and the transfer of responsibility may be a subtle process involving successive attempts before assuring readiness for greater responsibility.
(p.35)

This division of responsibility reflects the 'scaffolding' or support, where the adult 'controls' those elements of the task that are initially beyond the learners' capacity, so permitting him to concentrate upon and complete only those elements that are within his range of competence. According to Rogoff this results in the development of task competence by the learner at a pace that would far outstrip his unassisted effort. Over the course of learning the highly supportive scaffolding is removed interactively so that the child continues to participate at a comfortable yet challenging level. Rogoff goes on to advise that adults can test the child's readiness by reducing the level of scaffolding, thereby allowing the child to participate to a

greater extent. However if the child indicates lack of understanding, the scaffolding can quickly and subtly be re-erected.

Transfer of responsibility for the task is jointly managed. As the child develops the support is adjusted to a level just beyond that which can be managed independently, thus recognising the potential within the zone of proximal development. Vygotsky believed that in most settings adults and children work together to bring the child from his or her initial level of mastery gradually to the most advanced level of activity the individual can achieve. The process begins with the adult doing most of the cognitive work, followed by sharing of responsibility between adult and child until finally the child is able to perform independently.

the collaborative arrangement of children's learning includes transfer of responsibility to children as they become more capable of handling problems. Transfer of responsibility for managing solutions may involve close engagement to ensure challenging but comfortable level of participation
(Rogoff 1990 p.20)

Rogoff reinforces the view that in collaboration the child can always do more than he can independently but reminds us of Vygotsky who stated that:

he cannot do infinitely more .. what collaboration contributes to the child's performance is restricted to limits which are determined by the state of his development and his intellectual performance (p.209).

Conclusion

According to Vygotsky, everyday human learning is a context dependent and socially mediated activity. Rogoff extends the work of Vygotsky by stressing the interrelatedness of roles and the importance of tacit and distal as well as explicit face to face social interaction in guided participation. Rogoff also elaborates on the role of children as *active* participants in their own development. While her work focuses on infancy and childhood she acknowledges that development is assumed to proceed through the lifespan. Lave and Wenger also recognise the influence of Vygotsky and

identify the 'situated' nature of learning and the effect of 'sponsorship' on an individual's learning in a new environment.

Given that preceptorship involves a student being assigned to an experienced practitioner in the context of clinical practice, it is appropriate to utilise a sociocultural framework in which to locate and analyse the data. The approach to the study and the methodology will now be explained before the findings. Rationale for the theoretical framework will be extended in the next section.

CHAPTER 4

CHAPTER 4

APPROACH TO THE STUDY

4.1 Introduction

This chapter will provide a detailed account of the approach to the study. The aim, purpose and methodology will be explained before the research process. Within the research process section, data generation, management and analysis procedures will be illustrated. Unlike many studies, some of the preliminary findings and emerging issues will be identified in this section to demonstrate and justify a change in analytical direction.

Background

The approach to the study was driven by the underpinning question: *Does preceptorship facilitate student learning?* In order to find a response to this question it was felt necessary to explore the student experience of preceptorship, to ask the students what it is like to have a preceptor and how this influences their learning in practice. The data collection and analysis would then seek to develop understanding of the process. To this end a qualitative research approach was undertaken.

The literature review pertaining to preceptorship highlights a dearth of empirical research to support the widespread adoption of the practice in nurse education programmes in the UK. A growing body of literature offers anecdotal and descriptive information regarding the utilisation of preceptorship and the preparation of preceptors in particular colleges. Review of the literature from the United States, where the practice is more widely used, demonstrates a move towards systematic measurement and evaluation of preceptorship using quantitative research methods.

Reflecting on the literature from the United States the focus has been on experimental research studies aimed at measurement, and more recently evaluation, of the influence of preceptorship on development of clinical competence and role socialisation. However, given the fundamental differences in health care, nursing and education in the USA compared to the UK, it is argued that the findings from such studies cannot be generalised or transferred freely to nurse education in the UK. It is therefore essential to develop substantial research to explore the value of preceptorship in nurse education in order to support or refute the utilisation of such a resource within the UK context.

As preceptorship is a relatively new concept in pre-registration nursing and there is no established underpinning theory, the generation of new knowledge to guide future developments was required. In order to explore the concept and produce rich, descriptive and explanatory information it is argued that a qualitative research methodology is appropriate. Morse & Field (1996) advise:

Qualitative methods are used when little is known about a phenomenon or when present theories need revising (p.15).

The goal of qualitative research is to develop theory, establishing understanding and insight into the real world of the participants.

Qualitative inquiry is a process of documentation, description, identification of patterns and concepts and creating theoretical explanations in terms of reality (Morse & Field 1996).

A qualitative approach would therefore facilitate exploration of the concept of preceptorship from the perspective of those involved i.e. the students, identifying perceptions and experiences while highlighting issues important to these participants.

4.2 Interpretive Tradition

The qualitative approach taken to explore the student experience lies within the interpretive research tradition, a tradition which seeks to understand the meaning of human experiences. The major divisions within interpretative or hermeneutic traditions can be categorised in several different ways, nursing literature for example separates them into three methodological divisions: phenomenology; ethnography; and grounded theory.

Thorne et al (1997) explain that nurse researchers generally sought epistemological credibility in these three primary directions: the phenomenological project within philosophy, the grounded theory project within sociology, and the ethnographic project within cultural anthropology. However the complex relationships between the methodological standards and the larger objectives of the discipline are recognised:

ethnography's rules derive not only from the desire to document human variation, but also from the passion for discovering human universals. Phenomenology's methods assume the general philosophical stance that there is essential structure to human experience. Grounded theory methodology is dependent upon the assumption that human social processes beyond individual consciousness constrain and explain behaviour (Thorne et al 1997 p.171).

Lowenberg (1993) presents an alternative classification deriving from and more congruent with the broader philosophy of science and social science views. She acknowledges that distinct interpretations of the same term stem from differences in disciplinary assumptions, divergent approaches within each discipline, and the evolution of these interpretations over time. She highlights the importance of exploring the complex issues underpinning the interpretive approaches and not rigidly defining or constructing artificial boundaries too quickly.

Methodological variation from these traditions by nurse researchers was not however encouraged within academic establishments, in fact it was often demeaned as mixed

methods or method slurring (Thorne et al 1997). As a result accusations of an obsession about methodological integrity have ensued such as 'methodolatry' as described by Janesicck (1994) or 'fetishizing' as described by Atkinson (1995). Acknowledging these accusations Thorne et al (1997) strongly encourage qualitative nurse researchers to make explicit their departures from tradition, to name them as distinct methodological approaches and thereby to begin the process of legitimising them within our scholarly discourse. They put forward a credible argument for 'interpretive description' as one approach that can be applied to qualitative inquiry to create a sound interpretive description that contributes directly to our understanding of how people experience their health and illness for the purpose of developing nursing knowledge.

Koch (1996) adds an important philosophical dimension to this argument. She takes the position shared by Gadamer (1976) and Van Manen (1990) who suggest that there is no method, there is only a tradition, that is:

.. a body of knowledge and insights, a history of lives of thinkers and authors, which constitutes both a source and a methodological ground for present human science research practices ..

In the work of Koch (1996) 'methodology' includes the philosophical framework and assumptions underpinning the research. She suggest that a certain mode of inquiry is implied in the term 'method', methodology is the theory behind the method. Introducing a hermeneutic inquiry in nursing she states:

This methodology describes the process by which insights about the world and human condition are generated, interpreted and communicated. In terms of research practice it means recording the way in which a study is accomplished (p.174)

Common to both Koch and Thorne is the deviation from traditional fixed methods. Each of these researchers identify the importance of justification and provision of a clear, logical audit trail. Moreover, concern for rigour and trustworthiness in

communicating each step of the research process is essential in the production of a credible research report.

In the first part of this present study the principles of grounded theory were used to generate a large volume of rich data. However, artificial methodological boundaries were avoided by continuous analysis of the questions arising from the data. Rather than slavishly following one approach, specific questions arising from the data demanded a change in analytical direction and subsequent change to the methodological framework. While this may seem an unusual, even a questionable approach to qualitative analysis, deviation from traditional approaches will be made explicit and will be justified throughout the thesis.

4.3 Method

4.3.1 Purpose and Aim of Study

The overall aim of the study is to identify the perceptions of student nurses towards preceptorship and illuminate their experiences of having a preceptor in clinical practice. The purpose is to develop a theoretical understanding of the practice which illustrates the influence of preceptorship on student's learning and informs future planning.

Overview of the Approach

At the beginning of the study grounded theory as described by Glaser and Strauss (1967) was the approach used to guide the research. This approach was chosen, and deemed appropriate, because of the relatively unexplored nature of preceptorship, and the need to investigate the student experience. With this approach the emerging theory produces hypotheses which guide subsequent data collection and analysis before generating an explanatory theory. However, while data were collected and hypotheses generated and tested in subsequent data collection and analysis, other questions were raised which led to a change in methodological direction. The emerging themes raised questions which required further investigation to explain the student experiences. Therefore, rather than generating an explanatory theory from the data as in grounded theory, the data guided the research towards an existing body of knowledge. A framework of explanation was then taken to the data to explore the relationship between the student experience of preceptorship and existing theories of cognitive development.

The use of this combination of approaches, while it may be criticised by some, strengthened the depth of analysis and subsequent theory development. The grounded theory's particular methods allowed for illumination of the social interaction and relationship between student, preceptor and context. Although many

questions were answered through this approach, other questions were raised which could not be answered within the data. A change in the analytical direction allowed for exploration of an existing body of knowledge. This existing body of knowledge provided a framework within which the data was interpreted and explained. Utilising both approaches has allowed for the complexity of learning in practice to be acknowledged and understanding to be enhanced.

4.3.2 Grounded Theory

Chenitz and Swanson (1986) define grounded theory as:

a highly systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena (p.3).

Initially it seemed that a grounded theory approach would be appropriate because rather than beginning with a theory and collecting data for verification, as in quantitative and deductive research, grounded theory begins with a general question about what is going on in the area. Given the dearth of research explaining the student experience of preceptorship this appeared to be a useful starting point in the research process. As data were collected and analysed a process of discovery and theory generation evolved, i.e. an inductive interpretative approach was used. In terms of preceptorship this seemed to be an appropriate method to find out .. what are the students experiencing through preceptorship? what is happening in the process? Is student learning facilitated? and if so in what way?

The roots of grounded theory lie in the symbolic interactionist tradition derived from the Chicago School of Sociology between 1920 and 1950. The symbolic interactionist approach is based on three premises:

- Human beings act towards things based on the meanings things have for them.

- The meaning of such things is derived from the social interaction that the individual has with his fellows.
- Meanings are handled in, and modified through an interpretative process and by the person dealing with the things they encounter.

(Blumer 1969 p.2)

Symbolic interactionism stresses that human behaviour is developed through interaction with others and that people construct their own reality from symbols around them. For the interactionist the self is socially constructed through ongoing social interaction. The symbolic interactionist view takes into account 'the world' we live in, i.e. the social world as interpreted or experienced rather than the physical world. Within the social world objects have no meaning, their meaning is derived from how people react towards them. If objects are defined by the meaning they have for us and how we act towards them then their meanings may vary from one individual to another and as such reality for one person may be very different from the reality of another. Not only is reality different for different individuals, but it may also change for one individual from one time to another as they grow and develop and from one context to another.

If we accept that each individual's object world is different from an other's, this means that reality must be different for each of us. According to Blumer (1967) social or symbolic interaction is a complex active series of social processes involving the fitting together of lines of behaviour of the separate participants (p.70). For this reason it is impossible to understand the action of any individual or group by extracting them from the social context within which they were created. Individual action, therefore is always contextual.

The symbolic interactionist perspective has several implications for this research activity; firstly, human behaviour to be understood must be examined in interaction. As such, the setting, the implications within the setting and the larger social forces such as ideologies and events that affect behaviour are analysed. The full range and variation of behaviour in a setting or in relation to a phenomenon is examined to

produce self and group definitions as well as shared meanings. In order to do this the researcher observes and describes social behaviour as it takes place in the natural setting. The actual setting is examined for social links, ideologies and events that illustrate shared meanings held by people in the interaction and the effect their behaviour has on the interaction (Blumer 1969).

The second major implication of this perspective is that the researcher needs to understand the behaviour as the participant understands it, learn about their world, their interpretation of self in the interaction and share their definition. In order to accomplish this the researcher must 'take the role' and understand the world from the participant's perspective. Finally the researcher must translate the meaning derived into the language of the discipline in order for knowledge to be understood and accepted by the discipline.

Relevance to Current Study

The student experience of preceptorship is a socially mediated relationship occurring within a clinical setting. The experience of the student will therefore be dependent not only on past experience but also upon interaction with the preceptor as well as the specific context and the discipline of nursing. The interactionist perspective was seen as a useful framework within which to establish the research and begin to build an explanatory theory.

Principles adopted from Grounded Theory

The research process in grounded theory differs from most other research methods in relation to sequencing of steps. The phases of literature review, question/hypothesis generation, data collection and analysis occur simultaneously rather than as a sequence of distinct phases. Data may be generated from interview, observation and documents. This sequence of steps was felt to be appropriate in the current study because data emerging from interviews would capture the unique experience of the student, hypotheses would be generated which could then be explored in subsequent interviews. The data would also drive the research towards any relevant literature

source which may inform the study and could not have been predicted at the outset. This is reflective of the theoretical sampling process pertinent to grounded theory.

Theoretical Sampling is the **process** of data collection for generating theory and is a critical element of grounded theory research. Theoretical sampling involves the researcher in jointly collecting, coding and analysing data and deciding what data to collect next in order to develop a theory as it emerges (Glaser 1978). The data collection process is therefore influenced by outcomes of the emerging analysis. Successive stages are determined according to what has been learned from previous data sources. Glaser and Strauss (1967) distinguish between theoretical sampling and statistical sampling, the latter entails working through a predefined sample. In theoretical sampling the ongoing process of data analysis guides the development of interview questions and sample selection. Data collection and analysis are very closely linked throughout the process.

Melia (1987) identifies the scope for interpretation in Glaser and Strauss's discussion regarding theoretical sampling and extends the concept. Although she collected data from a specific predefined group, she used the idea that emerging categories dictate the direction and nature of further data collection by allowing the categories which emerged from the early interviews to determine the topics covered in later ones (p. 190). She goes on to argue that the ideas produced in the early stage of the study served to shape the line of enquiry, and in this way the data collection was directed by the theoretical notions which emerged. Like Melia's study, a predefined sample of student nurses was used in this current research and the direction of the study was dictated by the developments in each interview. The issues emerging from the early interviews were identified, analysed and compared to determine topics in the later. Given the dearth of empirical research relating to preceptorship, theoretical sampling allowed for the unique experience of each student to be explored and unpredictable issues analysed and developed.

Constant Comparative Analysis

The constant comparative method of analysis, which is central to grounded theory, was used throughout the study. This combines an analytic procedure of constant comparison with an explicit coding procedure for generated data. Comparisons are made continually as data are generated, for example: the first two interview tapes were transcribed verbatim, each line was examined to identify and conceptualise underlying patterns. The two interviews were then compared for similarities and differences, data then initially coded with substantive codes reflecting the substance of what was said. Codes were then compared, similar codes clustered, given an initial label and a category formed. Further data collection and analysis produced further categories. Data was constantly analysed for patterns of relationship between two or more categories. These patterns of relationship formed initial hypotheses which were tested in subsequent interviews, therefore, deductive as well as inductive methods were used initially.

Coding

Coding in grounded theory can be described as occurring at three levels, however only the first two levels were achieved in this study before a change in direction was indicated by the analysis.

First Level Coding as described by Field and Morse (1996) was carried out. All interview transcripts were analysed line by line and descriptive codes written in the margin. A descriptive code was attached to each concept described by the participant. Each incident was coded into as many codes as possible to ensure full theoretical coverage. As the information was coded, ideas, insights, thoughts and feelings about the relationship of the emerging theory were documented in the form of memos. This was essential to the process of analysis and the increase in the conceptual level of the research. Memos allowed the researcher to look for themes and patterns in the data while keeping track of valuable thoughts and ideas.

The **second level** of the coding process was to categorise. Categories are simply coded data that seem to cluster together. "The goal is to identify the relationships of the dimensions or properties of the categories. Categorising moves the coding process to a higher level of abstraction" (Morse & Field 1996 p.132). Here the data were constantly compared, categorised and recategorised until all the first level codes were condensed. Saturation was reached when no new information was identified which indicated that no new categories were emerging or that old codes needed expanding. Morse (1995) suggests that there are no rules that guide the process of analysis regarding saturation, except that initially no data are discarded or ignored. Rather, in the initial stages of analysis, all data must be given equal consideration in the analytic coding procedures. Frequency of occurrence of any specific incident must be ignored. Saturation involves eliciting all forms or types of occurrences, valuing variation over quantity. "Failure to achieve saturation not only severely impedes the quality of the research, but it also means that the researcher's task of theory development is more frustrating and more difficult" (p.149).

In grounded theory **level three coding** identifies core variables from the constant analysis. These variables are broad in scope and interrelate concepts and hypotheses that emerge during the analysis. Basic social processes (BSP) are a type of core variable that illustrate social processes as they continue over time, they are essentially the title given to the central themes which emerge from the data (Streubert and Carpenter 1995). "The goal of the discovery process is a theoretical description of the basic social process that is most central or problematic to participants in the investigation" (Glaser 1978).

In the current study several themes arose from this stage of coding. However, rather than pursuing a theoretical description of the basic social processes, the data analysis directed the research to seek explanation through another body of literature. This change in analytic direction is not unique. Since the original work of Glaser and Strauss (1967) questions about the research procedures still remain, some of which relate to identifying the investigation's core category (Schatzman 1991). Schatzman

argues that the aim of the analysis, as embedded in the symbolic interactionist approach, is to discover the meanings of those interactions as they create the observed situation rather than the discovery of basic social processes. The primary purpose of qualitative data analysis is to use the data in 'ways that will, first, facilitate the continuing unfolding of the inquiry, and, second, lead to a maximal understanding ...of the phenomena being studied in its context' (Lincoln & Guba, 1985, p. 224). To this end, to maximise understanding of the student experience of preceptorship, further thematic analysis was required.

4.3.3 Thematic Analysis

To continue along the grounded theory route would allow for presentation and description of the social processes which would explain the student experience of preceptorship. However, common themes consistently emerged from the data which guided the study towards a specific line of inquiry from which a framework of explanation was taken to the data. From this theoretical framework, an interpretive analysis began.

Interpretive description is supported in the work of Thorne et al (1997) who advise:

Interpretive description .. requires the researcher come to know individual cases intimately, abstract relevant common themes from within the individual cases, and produce a species of knowledge that will itself be applied back to individual cases (p.175)

Thorne goes on to advise that to do this effectively the researcher must engage in the earth bound concrete realities in order to produce sound and useable knowledge.

Sandelowski (1995) clarifies the distinction between qualitative analysis and qualitative interpretation in:

Qualitative analysis is a means of knowledge production that involves the separation of elements of data according to some a priori or data derived system. Analysis involves the break up or break down of the data ... which

permit the researcher to see the data in a new way. In contrast, qualitative interpretation is the knowledge produced: the end product of analysis where the researcher construes or renders the analysed data in such a way that something new is created that is different from, yet faithful to, the data in its original form (p.372)

She goes on to suggest that while analysis allows the researcher to see the data in a new way, interpretation is a creation of the researcher that permits the audience to see the target phenomena in a new way.

4.3.4 Summary

Within this study the principles of theoretical sampling and constant comparative analysis were used to generate initial data and drive the direction of further data collection. Utilising these principles a substantial volume of rich data was generated. First and second level coding was established, however, analysis of the data led the research process to deviate from the prescriptive method required to derive a true grounded theory. The structure imposed through the system of coding and categorising did not allow for exploration of other theories which appeared to be relevant to the development of understanding of the complex process of learning in practice and the influence of the preceptor. Deviation from the traditional method of grounded theory is supported by others such as Lowenberg (1993) who suggests that lack of structure inherent in grounded theory was difficult to adjust to and researchers began to structure the method to increase control and decrease the inherently high level of ambiguity ..

the focus on techniques and methods is at times at the expense of a thorough understanding of the underlying epistemological assumptions and the broad theoretical context in which the approach is located (p.62).

The data generated in this study raised many epistemological questions that demanded a broad theoretical approach. Ideas emerged which led the researcher to seek links in other theoretical perspectives. For example could understanding of the cognitive development processes in the student nurse possibly be explained through

theories employed to explain similar processes in child development? To seek answers to these questions a more critical and interpretative approach was required. A framework of explanation would need to be taken to the data rather than allowing the data to explain as in grounded theory. A thematic analysis was therefore adopted, the interpretive procedures employed will be explained as in the following sections of this thesis.

4.4 The Research Process

Beginning the Study

The first phase of the study was the pre-fieldwork stage where the quality of preparation was crucial to the overall quality of the study per se. Although detailed planning is not in the nature of interpretive research the course of the study was planned in a general sense, with an awareness that this would change and develop as the study proceeded. Sandelowski (1989) highlights the importance of this in:

the research proposal for a study that involves an emergent research design compels the investigator to negotiate the paradox of planning that should not be planned in advance (p.77).

This paradox is supported by Field & Morse (1996) who assert that it is difficult to be specific about a problem until data collection is underway. This was particularly significant in this study where the questions generated demanded a different route than initially anticipated.

The Setting

Clinical practice occurs in a diverse range of placements, both institutional and community orientated. The significance of the setting and its potential influence on the way in which behaviour is evidenced was acknowledged and taken into

consideration from the planning stage and throughout the study. To create a substantive theory there must also be an adequate range of variations in the phenomena so that definitions and meanings are grounded in the data. At the beginning of this study therefore careful consideration was given to the setting, the participants and also to the researcher's role, identifying and acknowledging any preconceived ideas and experience which may impact on the study.

The Researcher's Role

As the researcher I had also been involved as a teacher on the students' course. The potential impact this may have on the research relationship is acknowledged. However since the beginning of their course a very comfortable, informal and trusting relationship had been established and an open door, first name relationship had been achieved. Nevertheless, this made it even more important to explain the role of researcher, to acknowledge the different relationship in the research process and to assure confidentiality. Although acknowledged in the preparatory phase this was then reinforced at each individual interview.

Gaining Access

Prior to commencing the study permission was sought from the Principal of the College of Nursing and the Chief Area Nursing Office for the Health Board. A written request for permission (appendix 1) was followed by discussion to outline the proposal and the implications of the study. As both the College of Nursing and the Health Board have invested heavily in preparing registered nurses for their role as preceptors and in implementing preceptorship throughout the area no problems with permission emerged.

As this study does not involve patients or nurses during practice there was no requirement to submit the proposal to the Health Board Ethics Committee. This point was clarified prior to commencement and reviewed throughout the study in order to maintain ethical accountability.

Request for Participants

Having gained permission for the study the next step was to arrange access to students and request volunteers to participate. Volunteers were requested from students in the third year of the Diploma of Higher Education in Nursing. At this point the students would have had wide experience of preceptorship. The students were selected in two stages, twenty students from one class and a further fifteen from the next class six months later. While it was anticipated that this request would be made in the college setting at a prearranged time, this did not transpire due to changes in the students timetable and holidays. Instead a random selection of twenty students was chosen as the classes were about to enter the final stage of practice. Letters were sent to these students explaining the aim and purpose of the study, requesting their participation and assuring confidentiality.

Confidentiality

In assuring confidentiality the four basic rights of research subjects were adhered to i.e. the right not to be harmed; the right to informed consent; the right to self-determination; the right to privacy and confidentiality (Germain 1986, Wilson 1993). As all interviews were to be tape recorded it was essential to make this clear and to gain permission at the outset while assuring confidentiality regarding all information.

Response

Twenty letters of request were posted to students on the 21st October 1996. A tear off slip was appended to the letter confirming participation, and a stamped addressed

envelope was included for its return (appendix 2). Within two days the first positive response was received, with others following on subsequent days. This speedy response was very encouraging. A total of sixteen students from the twenty agreed to participate.

As each response was received this was followed up with a telephone call for which a checklist had been made, thanking the student for their reply and arranging a suitable time and place to conduct the interview (appendix 3). Permission to use a tape recorder during the interview was confirmed at this stage. While this seemed to cause some discomfort, evident in the spontaneous verbal response, none of the students refused the request. Each telephone call was then followed up with a letter of thanks, confirming the date and time of the agreed meeting and acknowledging the relevance and importance of their contribution to the study (appendix 4).

4.4.1 Data Generation and Analysis

The informal interview was the predominant mode of acquiring information, and was augmented by observational notes including recording of non verbal communication and spontaneous thoughts. Prior to the study it was anticipated that the student's learning contract would be a useful source of information. This is a document in which the student and preceptor record their aims and objectives as well as their assessment of learning during the placement. Although suggested during the telephone conversation, very few students brought these to the meeting. Those who did bring them used them mainly as a chronological reminder of their placement sequence.

The principles of critical incident technique (Flanagan 1954) were used as a strategy within the interview to elicit the student's experience of learning. During each discussion the student was asked to identify an interaction with the preceptor that proved critical to his or her learning, they would describe the interaction and how they learned from it. The students were already familiar with this technique and had experience of using it within their course work.

Interview Preparation

Prior to the first interview a semi structured schedule was designed, this shall be discussed in detail within the summary of the process (page 96). Although seven very broad questions were developed, with probes to explore the student experience, considerable flexibility was retained. The questions were used only as a guide and a stimulus, allowing the participant freedom to introduce topics which could not be anticipated by the researcher. The importance of flexibility is supported in the seminal work of Merton (1956) who said:

It is generally recognised that one of the principal reasons for the use of interviews rather than questionnaires is to uncover a diversity of relevant responses whether or not these have been anticipated by the enquirer (p.10)

Underpinning each interview was the concern with the student's subjective experience of preceptorship. The aim was to elicit the meaning the student accords to the experience, which could not be anticipated by the researcher.

Venue

As interviews were the predominant mode of acquiring information the environment in which they were conducted was crucial to developing an open relationship in which to generate rich informative data. It was essential that each interview was carried out in an area where the participant felt comfortable and also one that could

accommodate the use of a tape recorder. The choice of meeting place was therefore agreed with each individual student. While it was anticipated that the student would prefer the meeting to take place away from the college or clinical area, this did not seem an important issue to some students. Others however chose for the interview to take place in their own home. Although not anticipated at the beginning this was consistent with the students in Melia's (1981) study.

The aim to create as informal atmosphere as possible was realised through casual chat at the beginning. Interviews carried out in the student's home were all conducted over a cup of coffee. They were friendly, comfortable and conversational. Others were carried out in a variety of venues including quiet rooms in a ward, health centre, clinic and even in the college of nursing. Although some of the rooms were less than desirable this did not adversely influence the interview, a coffee was obtained where possible and light-hearted chat at the beginning was used to create a relaxed yet purposeful atmosphere. The students were very open in their conversation. They discussed their thoughts, feelings and personal experiences and provided rich, informative and very personal information.

Early Interviews

As a novice researcher the first few interviews were important not only in terms of the information elicited but also in terms of the crucial impact they had on my own learning and development. Even although I was familiar with the students and had established a comfortable rapport, I was surprised at how nervous I felt initially in the role of interviewer. The early interviews allowed me to become critically aware of my interview technique. The speed of my speech, which was increased through nervousness, caused some difficulty when transcribing. I also became aware of

interjecting and failing to develop emerging issues. These factors were modified in subsequent interviews.

Tape Recorder

Every interview was tape recorded. The students were made aware of the value of tape recording in allowing me to participate openly without having to take notes as well as to assure accuracy. Lofland and Lofland (1971) highlight the importance of tape recording in:

for all intents and purposes it is imperative that one tape records or otherwise preserves the interview itself. Because there is no strict order of questioning and because probing is an important part of the process, the interviewer must be very alive to the talk of the interviewee (p.88).

A 'Coomber' recorder was used because of the quality of recording and sound. The tape recorder was placed as inconspicuously as possible, partially hidden in a bag with only the microphone visible on the table. Some students appeared more uncomfortable with the recorder than others even although reassurance was given regarding confidentiality and accuracy.

Transcribing

Following each interview observational notes, reflexive notes and a brief summary were noted. The tape was then listened to and any preliminary thoughts recognised. Each interview was transcribed verbatim by myself as soon as possible. While this proved to be a very time consuming venture it also proved to be critical in developing familiarity which was crucial to gaining an intimate understanding of the student experience and what was important to the individuals, what was helpful to them and what was distressing to them. The virtue inherent in transcribing is recognised by Lofland and Lofland (1971) who said:

Transcribing tapes is a chore. But it also has enormous virtue. It requires one to study each interview. Listening to the tape piece by piece forces one to consider, piece by piece, whether he has accomplished anything in the interview or not. It stimulates analysis, or at least this is the proper frame of mind to adopt when putting the interview down on paper (p.91).

While each interview was being transcribed verbatim, thoughts and ideas were written in memo format, so that they could be followed up. Analysis was already underway, each transcription was read and reread, margin notes were made and initial codes ascribed. Following each interview a concept map was drawn to illustrate the codes, connections and emerging themes. The constant questions driving the analysis were: what are these students telling me? what are they saying that I need to follow up, confirm or refute?

On reflection the virtue of transcribing the interviews myself was continuously recognised at every stage of the analysis through familiarity, not only with data codes, but also with context. This familiarity prevented decontextualisation from its initial data source.

4.4.2 Data Analysis

Analysis began with the first interview and continued throughout. The method of analysis involved transcribing and considering each interview very closely. Each transcript was read and reread, along with field notes, to obtain a sense of the individuals experience. Reading was guided by the questions: what is this person saying? what are they telling me? The main issues were then identified and descriptive codes given to each topic. Hypotheses were drawn from the interview as well as any new ideas to be incorporated and tested in the next interview. In this way all leads could be followed up and no two interviews were the same. The first and second interviews were compared, looking for similarities and differences, before being coded to reflect the substance of the information. Similar codes were then

clustered, initially labelled and hypotheses generated to be tested in subsequent interviews. Analytical questions were developed to seek explanation and clarify issues. This process of data collection and analysis continued throughout; categories were formed, compared and recategorised. The data was condensed as the categorisation moved the data analysis and coding to a higher level of abstraction.

This iterative process was continued as each new transcript became available and was drawn into the pool of data. Powney and Watts (1987) identify this scanning and refining process, moving backwards and forwards between the raw evidence of the transcript and the developing analysis, as a classic example of the constant comparative method of qualitative analysis first proposed by Glaser and Strauss in 1967.

4.4.3 Data Organisation

Throughout the whole process of data collection and analysis, all ideas, emerging thoughts, feelings, hunches and intuitions were kept in the form of memos which provided written records and information for further analysis. Two hundred and twenty memos were written on file cards, each dated, and sorted into clusters. This process helped in organising the data and developing understanding of the relationship between raw data, categories and emerging themes.

As well as memos a personal journal was kept. This allowed wider thoughts, feelings and behaviours to be recorded. The journal provided a tool for personal reflections, helping to distance myself from the situation, and over a period of time identify personal values and bias which could influence the study. All generated data were then organised, labelled, dated, paginated and transferred to computer.

Concept Mapping

As a means of illustrating as well as organising the data a concept map was developed on completion of each interview. The main issues coming through were clearly identified and any related issues mapped out into themes. On completion of the first set of interviews, fourteen in total, six main themes emerged from the data. A concept map was then drawn out for each of the themes (appendix 5).

Northcott (1996) supports the use of 'cognitive mapping' as an approach to qualitative data analysis. He defines a cognitive map as:

a visual representation of the knowledge base of an individual .. it is cognitive in the sense that it represents the conceptualisation and interpretations of an individual and is set out 'thoughtfully' by the transcriber. It is mapped to allow all the ideas to be accumulated onto one page, including connections and interconnections, in an ordered and accessible manner (p. 458).

Given the volume of data generated from the interviews this proved to be an efficient way to organise the information. Drawn on A3 paper it allowed a picture to emerge of each interview in the first instance. It highlighted key concepts as they were identified, facilitating the generation of categories and themes and allowed interconnections to be made. In terms of rigour it facilitated a coherent trail of emerging concepts, comparisons and connections which would allow reflexivity to be traced and audited.

Data Management

Data organisation and management was essential given the large volume of data which, potentially, could have been, and at times seemed to be, overwhelming. Wilson (1993) highlights the importance of this process in:

the development of a good set of field notes not only relieves the investigator of some of the burdens of remembering events but also constitutes a written

record of the development of observations and ideas to be used in future publications of the research findings and method (p. 223).

Commercially available computer programmes for the analysis of qualitative analysis (e.g. Nudist) are available. Following a review of the literature as well as considerable thought, the decision was made not to use these. Russell and Gregory (1993) identify major issues to be taken into account by qualitative researchers when considering the use of a computer or manual data management system. They highlight the dearth of empirical research and the abundance of anecdotal information regarding the benefits and drawbacks of both manual and computer systems.

As a novice researcher, with limited information technology experience, it was decided at the outset to concentrate resources on the research process as well as on the fundamental computer skills required for organising, storing and retrieving data, rather than investing valuable time at the beginning on the technological skills required to utilise the more complex software packages. This decision was not only pragmatic but related to the value of working directly and closely with the data, acknowledging and justifying the generation of specific themes and categories. Such a decision is supported by Morse (1991) who points out that mechanising the analysis process may significantly increase a researcher's effort at least in the initial stages when learning and familiarity with a program may be time consuming. Weber (1986) has estimated that it takes the average user between 20 and 100 hours to get up to scratch with a software program. For myself this raised concern that valuable time for thinking and conceptualisation could be compromised.

While a specific software package was not utilised the intention was to become familiar with a word processing program in order to maximise its use in organising and managing the data. This was achieved and a separate program file was opened

for each transcript. During the stage of analysis, main themes were identified. Each transcript was copied and rigorously analysed and divided into as many themes as relevant. An individual file was opened for each theme and the data cut and stored in the identified theme or themes. While I was aware of the danger of 'context stripping' in this cut and paste process, I endeavoured to retain the sense of the context by frequently returning to the full transcript. Having spent many hours in the actual transcribing process I can still visualise each participant and the context of the interview in my mind's eye.

4.4.4 Rigour

Qualitative research has been extensively criticised for the subjective nature of the methods and associated risk of researcher bias. However, in qualitative research validity refers to the extent to which research findings represent reality, this study endeavours to explore the lived experience of the subjects. The use of external validity measures is therefore not appropriate to determine the credibility of the study, previously determined measures may in fact be at odds with the emerging theory. This reflects the underpinning philosophy and the associated belief that meanings are constantly evolving and do not remain static over time. While acknowledging the critics, it is argued that no research approach is immune to personal bias and human error. Entwistle (1984) recognises the weakness of the qualitative approach but argues its advantages outweigh the disadvantages in terms of a richer more informative picture of the real situation. A more appropriate measure of validity would therefore be the subjects' validation of the emergent theory. Entwistle goes on to suggest that the most powerful check on a study's validity is whether or not it describes a recognisable reality. The intention in the current study is to present the findings to a small group of participants as a means of checking the

interpreted reality. Also, throughout the process, many of the transcripts were read by two experienced supervisors, concepts and themes discussed and decisions justified.

A second major critique of qualitative studies is lack of reliability. This is acknowledged by Chenitz and Swanson (1986) who illustrate this through the often asked question . . . *"If I were to repeat this study would I find or generate the same result?"* They respond that perhaps the best answer is, *No!* Since the theory is derived from the researcher's best analysis, (skill, creativity, time, resources, analytic ability) no two analysts will be exactly alike, since no two researchers are exactly alike. However, the test for reliability is through the use of theory and its application to similar settings and to other types of problems over time. A more appropriate question to ask would therefore be, *"If I apply this theory to a similar situation will it work, that is allow me to interpret, understand and predict phenomena?"* The answer to this question should be, *Yes!*

These criticisms of qualitative work have evolved because empirical researchers believed there was a lack of control over the validity and reliability of findings. Lincoln and Guba (1985) present a strong case for replacing the concepts of internal validity, external validity (generalisability), reliability, and objectivity with credibility, transferability, dependability and confirmability, which more accurately reflect the assumptions of the qualitative paradigm.

In defending the value and strength of qualitative research the importance of rigour is highlighted. Rigour in any research is required to prevent error. However, as well as to rigour, attention must also be paid to trustworthiness in qualitative research. Sandelowski (1993) asserts that measures taken to safeguard trustworthiness are

complex and that the researcher must examine them carefully before selecting those that are appropriate to the research at hand. In order to demonstrate rigour and trustworthiness emphasis is placed on the development of an "audit trail", clearly documenting research decisions, choices and insights (Morse & Field 1996). Subjective interpretations of events are recorded throughout this study as a means of alerting the reader to areas of potential bias. A personal journal has been kept and used for personal reflections with the aim of detecting bias.

Exploring the problems of rigour in qualitative research Sandelowski (1993) alerts researchers to the expense of making rigour an unyielding end:

There is an inflexibility and an uncompromising harshness and rigidity implied in the term 'Rigor' that threatens to take us too far from the artfulness, versatility and sensitivity to meaning and context that mark qualitative works of distinction (p.3).

She goes on to suggest that rigour is less about the adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work. Like Rose and Webb (1998), I did not want to establish rigour at the expense of stifling the creative element in data analysis. In adopting principles from more than one approach I attempted to avoid too rigid rules which would merely stifle what I believe is a creative endeavour. My intention throughout the study is to demonstrate an understanding of what I did and why I did it, I shall therefore now summarise the process of data collection and analysis, justifying each step and defending the way the data were analysed with rigour. A 'watershed experience' shall be described to highlight two distinct phases of the study and explain the analytical and methodological change in direction.

4.5 Summary of Process

As I embarked upon the study I had little idea of how the route would progress. Looking back two distinct phases of data generation and analysis are evident. I shall now endeavour to summarise the process and illustrate the analytical and methodological direction before presenting a more full analytical picture in the next chapter.

4.5.1 Phase 1: Interviews 1 - 14

Interviews 1-14 constituted the first phase of the data collection and analysis. The interviews could be characterised as reflexive interviews as described by Hammersley and Atkinson (1983). While there was an underlying structure and agenda, the direction in which the interview developed was determined by the individual student and their experience. I wanted to find out what preceptorship meant to the students and what their experiences were like. The first question in the first set of interviews therefore aimed to clarify the students' interpretation of preceptorship and set the scene for further more exploratory questions. The second question asked each student to describe their experience of preceptorship. This question was then the driving force for the remainder of the interview. Seven main questions, with rationale, were developed. While this may appear restrictive, the questions were open ended and aimed to provide a guide for the interview while retaining flexibility to follow leads from each individual.

Interview schedule

Introduction to the interview and preamble was important in creating a comfortable, informal atmosphere. This was achieved through conversation in which the aims of the study and roles were clarified. The rapport established at this point was crucial to the quality of the data generated. The main questions within the framework were:

- *What do you understand by preceptorship?*

As preceptorship is a relatively new concept for the student it seemed important to clarify the individuals' understanding of the concept.

- *Tell me about your experiences of having a preceptor.*

The aim of this prompt was to establish any issues important to the student. This allowed individuals to discuss their personal experience, expectations, perceptions, first impressions as well as changes through their development.

- *The preceptorship system aims to facilitate student learning from practice; in what way, if any has it helped your learning?*

Any links between preceptorship and learning were explored. Probes were used to detect influence on knowledge, skill and competence development. The participants were asked if they could think of a critical learning incident which would illustrate an experience of learning when with the preceptor.

- *Looking back over the course, to what extent has having a preceptor influenced your clinical practice experience?*

The rationale for this question was to clarify the way in which preceptorship may influence a placement. The aim was to differentiate between social and learning influences.

- *What would you say has been the most important influence on your learning in practice?*

This question aimed to allow a shift of focus from preceptorship and explore other factors which influence learning in practice.

- *As you are nearing the end of your course you will soon find yourself in the role of preceptor. Reflecting on your own experience, what would you hope to achieve as a preceptor?*

It was anticipated that such a question may elicit the individuals' perception of the important features of preceptorship.

- *Is there anything else you want to say about the topic that I haven't asked about?*
Is there anything you want to ask me?

I wanted to ensure the student had opportunity to introduce or reinforce any issues of personal significance or importance.

To conclude the interview each student was thanked for their time. The value of their contribution to the research was acknowledged. Permission was requested to contact again should clarification, or future participation in a focus group, be required as part of the validation process.

Following the first two interviews I asked the students for some feedback on the process based on the following questions:

- How did you feel about the interview?
- Did you feel comfortable with the questions or were they threatening in any way?
- Did you have enough time to think about the answers?
- Did you feel that you were being led in any way or under pressure to say more than you wanted to?
- Would more information at the beginning have been helpful?
- What about the letter, was it quite clear?
- Could you have been made to feel more relaxed?
- Any tips for making subsequent interviews more successful?

The response to these questions was very positive. The students said they felt quite relaxed during the interview. They were conscious of the tape recorder, particularly at the beginning, and made reference to it spontaneously. Each however appreciated the importance of recording. One student suggested that the questions could be sent out before the interview, this would give them time to think of their responses. This

was discussed and I voiced concern that this may reduce spontaneity and therefore restrict responses. It was agreed that in the telephone conversation I would suggest the participant give some thought to their experiences of preceptorship and try to think of a critical learning situation prior to the interview.

Process

Prior to the first interview the sequence of questions was developed to allow for broad discussion before focusing on the influence of preceptorship on learning. This was, however, constantly reviewed and modified depending on the emerging issues. The schedule was used more as a guide than a set list of questions to be addressed in order. For example the question exploring the most important influence on learning in practice was found to be inappropriate and leading in the initial sequence. Following discussion on preceptorship many participants responded in favour of preceptorship and had difficulty changing focus. It was decided that in the next phase of interviews it would be more appropriate to begin with this question, seeking spontaneous responses, before picking up on and allowing a shift in focus to preceptorship.

Each interview was conversational in nature. Many and diverse issues were introduced by the student and developed to illustrate their personal meaning. Constant comparative analysis was established from the outset and each issue identified by the participants was pursued in subsequent interviews. For example, the first student identified her branch choice as an important factor in her experience of preceptorship during the common foundation programme. This was not an issue anticipated prior to the interview, therefore a question related to branch choice was incorporated into the next and subsequent interviews. This process continued throughout and is consistent with the theoretical sampling procedures described by Glaser and Strauss (1967) and Melia (1987). The ease with which the participants shared their thoughts and feelings about their experience resulted in a very rich and valuable set of data. This was to make the constant comparative analysis exciting as well as complex.

By the end of interview fourteen a substantial amount of rich data had been generated, including, field notes, transcriptions, concept maps and over one hundred memos. It was therefore necessary to suspend further interviews to allow 'thinking time' and more rigorous analysis and generation of hypotheses to be tested in the next phase of the study. This decision may be appreciated from a particular journal entry which describes the stage I was at in the research process:

I feel as if I am in a jungle - there seems to be so much and I wonder where I should go from here. I haven't enough focus and seem to be identifying many different avenues to follow such as the relationship; learning context; socialisation; professional development ; but they are all interlinked

This 'jungle' was disentangled through discussion, further reading of the transcriptions and analysis based on the underpinning question 'What are these data telling me?' As clarity emerged the main themes were established and further, more theoretical, questions generated.

On retrospect, suspending the next stage of interviews for approximately three months was critical to the development and methodological direction of the study. While initial themes and hypotheses clearly emerged, analysis of the data identified questions which could not be addressed within the grounded theory framework. Theoretical questions directed the study to explore links within a different theoretical perspective. This demanded a different line of enquiry and subsequent change in analytical direction. The change will now be illustrated by outlining the initial themes as well as explaining the line of enquiry directed by the analysis.

4.5.2 Emerging Categories and Themes:

Constant comparative analysis of interviews one to fourteen led to the formation of five initial categories:

'fitting in'

'building relationships'

‘learning’

‘confidence building’

‘letting go’

Each of these categories was developed from initial codes which reflected the recurrent issues identified by the students. For example, being expected; welcomed; introduced; getting involved; getting to know the staff and patients were initial codes clustered with similar topics which then created the category ‘fitting in’. Being accepted; establishing relationships; trust; respect; were some of the issues within ‘building relationships’. Participation; observation; supervision; practice; discussion; working with staff and feedback were a few of the topics within ‘learning’. The need ‘to do things’ with supervision; gaining experience; gaining confidence; feedback; contributed to ‘confidence building’. Finally, the need to do things without supervision; developing autonomy; being trusted; formed part of ‘letting go’.

Constantly working with these issues and categories identified many overlapping and influencing factors. The individual preceptor, for example, would have an effect on each of these categories as would the context or clinical environment. The interrelationship between each of the categories was clearly evident. Further analysis identified not only the potential for overlap within these categories, but also the limitation within the category for allowing more rigorous inquiry to explain the findings. Following from these initial categories, six more broad themes were developed within which the data would be examined and explained:

- Preceptor (characteristics/role)
- Relationship
- Learning
- Context
- Socialisation
- Professional development.

These themes provided a framework for the next level of analysis. Each of these themes were reviewed and reorganised in the second phase of data collection and will therefore be illustrated, discussed and explained more fully in the next chapter. In the meantime, the process through which the early analysis led to a change in direction will now be outlined.

4.5.3 'Watershed' Change in analytical direction

While deliberating on the issues and themes from the early data analysis and on the direction for the next round of interviews, the importance of practice, participation, guidance, support and supervision to the student experience of learning was established. The significance of guidance and participation in particular, stimulated a literature search which led to the work of Rogoff (1990), who developed the concept of 'guided participation' in her work on child development. At this point, I began to wonder if the student experience, and the complexity of learning within the clinical environment, could be explained through existing theories of learning and cognitive development which have been previously unexplored in the nursing context. The concept of 'guided participation' and the work of Rogoff led to further exploration and to the sociocultural theories of learning.

Rogoff's work focused on the process of cognitive development in children and she developed the concept of 'guided participation' as a perspective to explain how children's development occurs through active participation in cultural systems of practice. In such a system children learn and extend skills, values and knowledge of their community. In her work development is considered as 'occurring through their active participation in culturally structured activity with the guidance, support and challenge of companions who vary in skill and status' (Rogoff et al 1993). Children's development is seen as a creative process of participation in communication and shared endeavours that both derives from and revises community traditions and practices.

While Rogoff suggests that both guidance and participation in culturally valued activities are essential to children's development, similar processes appeared from the data to be essential to the development of the student in nursing. The participants in the present study recognise the need for guidance and participation to develop knowledge, skills and values essential for competent nursing practice. They also acknowledge the influence of more experienced practitioners in facilitating learning and development. The question then arises, 'to what extent, if at all, could preceptorship influence the cognitive development of students in clinical practice?' If the cultural arrangement of nursing is considered as a community, could it be that those strategies which influence cognitive development in children, are similarly used again by adults as they enter a new cultural domain such as nursing? These questions demanded further attention.

4.5.4 Summary

This three month period of analysis was considered a 'watershed experience' in relation to the direction of the study. At the outset it was anticipated that a grounded theory approach would be followed to explore and develop understanding of the concept of preceptorship and construct a theory which would illuminate the student experience. However, reflecting on the responses in this first phase, broader issues pertaining to the nature of learning in practice were emerging. The question now persisting was, *would it be appropriate to deviate from this grounded theory approach to allow exploration of theories which may explain the cognitive processes of development described by the participants?*

The second phase of the study was entered with this question in mind. The decision to continue the data collection by exploring and developing the issues raised, while seeking confirmation of the findings established, seemed appropriate. However, as well as this iterative process allowing for verification, a selective review of the literature from the sociocultural field would be carried out concurrently to probe established theories of development for links with nursing education.

4.5.5 Phase 2: Interviews 15 - 25

The second phase of the study incorporated interviews 15 - 25. A new interview schedule was developed based on those findings and issues raised in the preliminary analysis of data. The main questions within the revised framework were:

- *What has been the most important influence on your learning from practice?*

This question was addressed in the previous interviews but because of sequencing was felt to be leading. The rationale for the question was to establish the student perception of factors which influence learning. By using it as an opening question a more spontaneous response was anticipated.

- *To what extent has having a preceptor influenced your practice? Or In what way (if any) has having a preceptor influenced your practice?*

The aim of this question was to verify the extent to which a student benefits from having a named preceptor.

- *Looking back, what did you need from your preceptor at the beginning of your course? What would you need from them now? Why/In what way is this different?*

The aim of these questions was to verify that student's needs do change over the course. To explore and clarify not only the changes in expectations but developmental changes in self image, confidence, perceptions of nursing and learning identified by previous participants.

- *Looking back there may be some areas you have enjoyed more than others. In what way, if any, did your feelings about an area influence the way in which you learned?*

The aim was to find out to what extent the student's level of comfort; interest; and enjoyment influenced the approach to learning.

- *To what extent did it make a difference if the preceptor had a programme planned for you?*

The significance of structure and planning was introduced by previous participants. The aim now was to explore the effect of planning and structure on the learning experience. Was it the fact that they had a programme or was the programme a vehicle for communication?

- *Is there anything else you want to say about the topic that I have not asked? Is there anything else you want to ask me?*

Again to ensure the participant has the opportunity to introduce any issue of personal significance/importance.

4.5.6 Process of analysis

The process of constant comparative analysis continued throughout this second phase with each interview driving the data collection and still directing the study. Transcribing, coding and analysing continued concurrently, the developing themes becoming progressively more focused as hypotheses were tested. Concept maps continued to produce a pictorial representation of each interview, and ultimately each main theme. As the data collection proceeded the process of analysis moved from a descriptive to a theoretical level. The main change, however, was in the use of the literature. Selective sampling of the literature now explored for links with the sociocultural theories of learning. This allowed for critical examination of the data against existing theories in search for explanation.

Summary of Themes

On completion of the interviews, the process of analysis continued. The initial six themes were reviewed and condensed. The themes of preceptor and relationship were interrelated and merged into one for further analysis. Learning was expanded to the 'process of learning' which included strategies and consequences. Context and

socialisation merged into one theme entitled 'the learning environment' which included the influence of the context on student socialisation and learning. Student needs emerged as a theme within which perceptions were recognised, analysed and implications explored. Professional development was expanded to include personal development and the processes involved, the theme now entitled 'process of development'

Within the following chapter each of the resulting themes: preceptor; learning environment; process of learning; student needs; process of development; will be described, discussed and explained. An interpretive discussion will then follow which will illustrate the change in analytical direction and the way in which the literature was used to explain and inform the study.

CHAPTER 5

CHAPTER 5

FINDINGS

5.1 Introduction

This chapter will present the main findings of the study. The themes emerging from the analysis: the preceptor; learning environment; process of learning; student needs; and process of development will be described, discussed and to a certain extent explained. An attempt will be made to 'bring alive' the student experiences through the extensive use of direct quotations. Each quotation is coded with reference to the particular interview transcript and page number (interview number/page number). Some issues will be addressed within more than one theme so that they can be viewed from different perspectives. For example, characteristics of the preceptor-student relationship are identified within the theme 'preceptor' but addressed again as influences within 'process of learning'. The aim is to illustrate the students' experience and identify their perceptions of the influence of preceptorship on learning. This will be followed by an interpretative analysis within a sociocultural framework.

Description of Themes

5.2 The Preceptor

The opening question of the interviews aimed at clarifying the students' understanding of preceptorship before exploring their experience of 'having a preceptor'. The main theme which emerged from the analysis focused on the characteristics of the individual preceptor. The student expectations will be

described before identifying perceptions of characteristics, roles and responsibilities of the preceptor.

Expectations:

The participants perceived preceptorship to be a formal system of learning support in practice. Prior to their first experience the expectation was that there would be someone there, a named individual who would provide support in practice. Many students expected this person to be with them constantly, to work with them, 'to show' them what they were doing, and to provide experience for them.

The majority of students understood the preceptor to be a role model, someone who would be interested in them as an individual and would help them to learn in practice. They also expected the preceptor to be someone who had a particular interest and desire to teach students, this became clear in comments such as:

I thought preceptors were people who had especially gone on courses because they were really interested in passing on their knowledge .. like especially chosen for the job (17/5)

More specifically the preceptor was seen as someone who would guide, teach and ensure that they (the students) were doing no harm. Someone they could confide in and go to with any problems. Without exception the participants perceived the preceptor as someone there to provide support.

The expectation of 'having someone there' provided reassurance and reduced the initial anxiety when going to any new placement. The quality of the overall clinical experience was, however, influenced by the individual preceptor and the relationship formed.

Experiences

When discussing actual experiences of preceptorship the participants immediately identified and compared positive and negative experiences. Implicit in each of the interviews was a vision of what the students perceived to be 'good' and 'bad'

preceptors. A significant volume of data describing the preceptor was generated, for organisational purposes this will be condensed and presented under the following headings:

- Personal Characteristics
- Relationship
- Role Perceptions/Expectations
- Nursing Practice

Personal Characteristics

A wide range of personal characteristics was identified by the participants to describe individual preceptors and their influence on the preceptorship experience. A major factor identified by each student was the effect of the preceptor's attitude towards them. This influenced not only their satisfaction with the placement but also the extent to which learning outcomes were achieved. The first, and most consistent, attribute used to describe the preceptor was 'interest'. The 'good preceptor' showed interest in the student as an individual and as a learner. When the preceptor was interested a relationship was established. The preceptor got to know the student, the course stage and associated requirements and subsequently treated each student as an individual. This in turn helped the student to feel valued and work towards achieving goals. Inherent in this interest was a positive attitude towards precepting. They wanted to have a student and made the student feel welcome in the clinical area. This link between interest and desire to precept was expressed by many students and is evident in the following comment:

What I would want from (the preceptor) .. I would want it to be a person who was interested in what I was doing, I would want it to be a person who was doing it because they wanted to do it, because I think that is really important .. if they are doing it because they have to do it .. not because they want to do it that makes a big difference (6/9)

The importance of preceptor interest was evident in every interview and referred to in descriptions of both positive and negative experiences. The relationship between

preceptor interest and student learning may be gleaned from the following comparison:

'I've had other experiences where the preceptor just wasn't interested in me, didn't involve me and I would have been as well not being there .. you learned very little, they just left you to get on with it' (24/2)

The link between preceptor interest and student learning is supported in the work of Baillie (1993) who used a phenomenological approach in a study of student learning in community placements and stated: 'where mentors were positive and interested, it appeared that they were more likely to act as facilitators of learning, by organising a variety of experiences and promoting all learning opportunities' (p. 1050).

The importance of taking an interest in the student which involved 'getting to know' and 'treating as an individual' is also supported in a recent American study by Nehls, et al (1997). These authors explored the lived experience of students, preceptors and teachers and suggested that just as 'knowing the patient' is central to nursing practice 'knowing the student' is central to the practice of teaching. They go on to acknowledge that in order to teach nursing thinking there must be 'linear time' for discussion of nursing knowledge and demonstration of nursing as caring practice. The notion and impact of time is significant in the current study and will be addressed later. However, the link between time and interest is of relevance here. The participants clearly describe the 'good preceptor' who is interested, as someone who will take time to share their knowledge and experience and subsequently enhance the learning process.

While the students acknowledge that many clinical staff express interest and caring practices, it would appear that they recognise the preceptor as having a specific responsibility to demonstrate such characteristics in facilitating learning. It is therefore important to the student to be assigned to a preceptor who is interested. However, to be valued this interest must be real and genuine, as one student said:

'The 'good preceptor' is more geared towards education and, focuses on achieving aims and goals ... with the preceptor it's more in depth and there is a chance for sort of like discussion and to reflect about how you feel you've done in a certain situation .. you may not get that with other members of staff, or if you do I haven't felt that there has been like .. genuine sort of interest there .. whereas with the preceptor beside me there is .. there is that interest there so that you can generate discussion and feedback' (16/2)

In exploring the manifestations of interest, the non verbal component and attitude was described in comments such as:

you can tell when they are not interested in you, you know .. laughs .. you just feel it .. you just sense it .. that they've got no time for you (3/26)

Comments such as these highlight the student perception and expectation of the preceptor role and its inherent responsibility for facilitating learning. Genuine interest is therefore essential for a positive preceptor student relationship to be established and developed.

The Relationship

The relationship established between the student and preceptor was crucial to the overall success of the placement. The more open and communicative the preceptor was in the relationship the more comfortable the student was in learning and developing in an open and receptive manner. This is consistent with the humanistic approach to learning and the work of Rogers (1983) who discusses 'the teacher' in terms of one who facilitates learning through forming a relationship in which 'realness' and 'genuineness' are essential characteristics. Rogers also identifies the significance of trust, respect and empathy within the relationship, characteristics which have been identified by the majority of participants in this current study as necessary for a positive preceptorship. One student expresses this in:

'you can't learn from someone you don't have any respect from .. the initial thing is getting that respect' (9/12)

The importance of establishing and building a relationship with the preceptor is acknowledged by the majority of participants. When addressed by name the student

is more likely to feel accepted and recognised as an individual, the following comment is reflective of the majority:

'it makes a difference when they remember (your name) and you are not just a number or .. that's the student' (15/12)

Prior to going to a clinical area the students express anxiety about who their preceptor will be and how they will get on with them. This anxiety persists throughout the course, even in the final placements, as identified by another student who said:

'I was kind of apprehensive, even although it was part six you still want to know what it's going to be like and what the preceptor is going to be like, that's always my first thought' (12/26)

The need to 'get on' with the preceptor was addressed by every participant and the impact this has on learning is reflected in comments such as:

I definitely think having a preceptor is a big help, if of course you can have a relationship with them, I definitely think it's wonderful .. I think you learn an awful lot more as well, you want to learn more' (7/25)

'I think if you come across the person that you can't get on with .. how can you effectively learn from that person? .. you can't' (6/14)

The above statements highlight the importance of establishing and building a relationship with the preceptor. The initial contact or introduction can reduce student anxiety. This, however, depends on many factors not least personality and attitude of both student and preceptor, as one student said:

'it's all about their personality, if you feel comfortable with someone you can work with them and relate to them and you can talk to them about anything' (12/12)

Recognition of their own attitude and responsibility for achieving trust and respect was clearly expressed by another student:

'preceptors can teach you a lot if they want to and you are open to their vast experience and you can take that on and be prepared to learn from them .. your attitude to them helps .. and I think how they approach you initially .. if

they treat you with respect and you reciprocate that then it opens it up'
(6/24)

The single most important preceptor characteristic in establishing a relationship is 'approachability'. Without exception the participants acknowledge the need for the preceptor to be approachable and recognise the impact this has on the relationship. These characteristics of approachability and interest have been identified in a number of earlier studies in nurse education, Fretwell (1982); Ogier (1982); Lewin and Leach (1982), to name but a few. What is apparent in the current study however is that these characteristics were more important in the early course stage when the student lacked confidence and competence in practice. As the student develops they become more confident in utilising a variety of personnel and resources to meet their learning needs whereas in the early course stage they are more likely to approach only the preceptor or another individual who presented a friendly demeanour.

When the student establishes a relationship with the preceptor they are more likely to relax and enjoy the placement. When they feel comfortable in the relationship they are more likely to use the preceptor, to learn from them and to discuss their fears and anxieties with them.

Role Perceptions/Expectations

The students' perception of the preceptor's role focuses primarily on the responsibility to teach, to supervise and to assess the student. They are seen to be responsible for facilitating the learning experience, planning a programme and organising any additional experiences such as visits or discussion with the multidisciplinary team. In short to provide opportunity for the student to learn. The students look to the preceptor to involve them in care delivery, to teach them by demonstration, discussion and allowing them to practice and develop skills under supervision. They rely on the preceptor for feedback on progress and development.

Although the contribution of all personnel to the learning experience is acknowledged, working with the preceptor was perceived as different from working with other nurses. One student articulates this in the following observation:

'working with the preceptor you felt as though you learned a lot more .. do you know what I mean? .. you were with her .. you were doing things with her and you would be asking questions .. she would be asking you questions .. but when you were with some other members of staff you were just getting on with it' (7/5)

While working with the preceptor is generally seen as very positive, concerns are raised by the participants in relation to the impact this has on other staff. There would appear to be the potential for many registered nurses to ignore their own responsibility for teaching and project sole responsibility onto the preceptor. It has become clear from analysis that good communication between staff is essential for each individuals' contribution to the learning process to be recognised and valued. A number of participants acknowledge this in comments such as:

'you weren't quite sure where to go because nobody was prepared to take on the role until the preceptor had said, look this is so and so and she is going to do such and such .. you know .. and when I'm not here she'll just be with the rest of the team' (25/3)

The potential for the preceptor role to become or be seen as 'elitist' and for staff to refuse to involve themselves with the student because it's not their role is of even greater concern. The impact this kind of response and attitude may have on a student is captured in the following experience:

'I had an experience in one placement the preceptor wasn't there for two days and I felt as though .. when I walked in for those two days I felt as though nobody had seen me .. I felt as though I was .. I don't know .. the invisible man ... laughs .. I thought .. can anyone see me there .. I was standing about for the first two hours but .. ahm .. what do you want me to do? .. the staff nurses were that busy they didn't seem interested in me and it wasn't until the preceptor had come in on that third day that he organised a schedule for me'

(3/32)

While it could be argued that this student could have been more proactive and accept responsibility for learning from such a situation, this is obviously very difficult in the early course stages. It is clear from the analysis that the majority of students do recognise their own responsibility for learning in practice, however a good preceptor can ease this process. One student makes the comparison in:

'.. I learned everything that I had set out to and met all my aims and objectives .. but that's a good preceptor .. if you had maybe not such a good preceptor you could say to them .. I want to do this and I want to do that .. and they would say, right .. yea .. yea .. and nothing would be organised, but then again it's up to the student to push for what you want .. but it just makes things easier if you've got a preceptor that's willing to help you achieve these things'

(14/19)

Comments such as these highlight the potential value and the collaborative nature of the preceptor role. The extent to which the student learns more in collaboration with a preceptor than he or she would in isolation is explored further in chapter 6.

Assessment

Each of the students recognised assessment as a major feature of the preceptors' role. Many commented on the importance of spending time working with the preceptor and developing a relationship with them because they would be involved in the assessment process. One student explained this in:

'well they're the person who is going to have overall say in the end .. about what grade you should be getting .. although it's discussed between yourself, your lecturer and your preceptor .. it's the preceptor that has been working with you .. you know .. so you try to get into their good books from the very beginning .. and try not to make any mistakes' (21/8)

This student refers to the tripartite assessment system where the preceptor, lecturer and student are each involved in the assessment process. A system of grading practice was also in place at this time. Students could achieve a satisfactory grade by achieving predetermined learning outcomes and competencies. A higher grade could, however, be gained by demonstrating critical reflection on practice through discussion with the lecturer. Although this grading system had been in place at the

beginning of the study, changes to a satisfactory/unsatisfactory system were in process of being implemented.

While the majority of the participants recognised assessment as an integral part of the preceptors' role, controversy over the grading system dominated any discussion. The majority of the students questioned the fairness of grading and lack of understanding of criteria for each grade. As well as acknowledging a degree of competitiveness among students, many participants also recognised the system as causing anxiety in the relationship with the preceptor. One student expressed this in:

'there were times when you felt as if .. this is my preceptor, this is the one that's gi'ing me the grade .. you felt a wee bit more under pressure sort of thing, knowing that .. whereas with other staff you were a wee bit more relaxed and then they would go back and say to your preceptor what had happened and how you'd got on' (13/4).

The anxiety caused by grading was referred to frequently and the change to the assessment system was welcomed by the majority of students. This is recognised in comments such as:

'I don't know if it would make a difference to the preceptor but I think it would make the student more relaxed you know, like the new system that's coming out .. satisfactory or unsatisfactory .. I mean that would put you at ease because you would know well it's a pass or a fail you are not getting graded, there is no as much competition, you know between the students, especially if there is more than one student in the ward .. there's usually quite a bit of competition (laughs)' (21/9)

The issue of assessment is without doubt of significance to the students' experience of preceptorship. The timing of the study, however, which coincided with the changes to the assessment system, did not allow for an objective discussion regarding the preceptors' role and the student's experience of assessment.

Student Role

The individual students' responsibility for learning is acknowledged throughout the study. Perceptions of their own role, however, are often influenced by the preceptor, as the following student explains:

'when you are working with the preceptor .. you are like a student and you are learning .. I'd say you are learning a lot more .. that way .. working with her because she is questioning you all the time with the drugs .. what's this for? .. side effects to it? .. so you were getting this constant every day from the preceptor and then you would go on to another ward and you wouldn't get that .. your learning is .. you are well just being an auxiliary basically, because you are not really doing a student nurses' job .. I've had that experience a couple of times' (23/5).

This tension between the role of the student and that of the auxiliary has been well documented within the nursing literature, particularly within the work of Melia (1987) and more recently by Gray and Smith (1999). While such tension remains evident throughout this current study what has become clear is the potential for the preceptor to influence such role perceptions. The preceptor can alter this tension by establishing a relationship, clarifying expectations and preparing a plan or programme to maximise experience and meet learning outcomes. This is acknowledged in the following comment:

'It really does make a difference (having a programme/plan) .. because the moment they show you like this is what you need to do .. you really feel like a student .. and you know you've got certain things to achieve ..' (11/5).

These comments highlight preparation, organisation and planning as integral aspects of the preceptor role. When the preceptor has a programme organised for the student this positively influences the learning experience and provides a vehicle for discussion and monitoring of progress. This also directly influences the overall learning experience by providing structure, which will be addressed on page 170.

Nursing Practice

In terms of practice the 'good preceptor' was perceived by the participants as a positive role model, someone who demonstrates good patient care. The preceptors'

attitude to the student was often reflected in their attitude to patients and families.

One student expresses this in:

'I think the ones that I've found to be really good preceptors .. were really caring towards the patients, do you know what I mean? And I think, maybe because they were just caring people .. and I've stood beside them when they've been dealing with patients and I've thought .. oh God, I want to be like you .. I mean I think they are just wonderful people .. and to the rest of the staff they're just .. they care ..' (7/21).

These preceptors worked with the students, involved them in care delivery and actively provided experience. They '*allowed you to do*', in the words of the students and were willing to share their knowledge, skill and expertise through discussion, reflection and narrative. The impact of the role model on student's learning is recognised in:

'I think you learn .. everything .. from obviously the practical skills .. eh you learn an awful lot .. you rely on them basically to show you the correct way .. ehm .. you learn .. I suppose you sometimes maybe develop some of their attitudes .. eh it does come across on you .. so basically the whole nursing you learn from them' (19/2).

In recognising the attributes of a positive role model, the students expected to be '*shown the right way*' by the preceptor. Therefore inherent within the perceptions of the preceptor role is the responsibility to ensure the students do no harm, and that they are safe in their practice and care delivery. The following comment is reflective of many:

'I rely on them to make sure I am doing no harm, I need their reassurance'

Although the students identify differences in practice and acknowledge the influence of all members of the team on learning, the evidence suggests that they depend on the preceptor to '*show the right way*'. They look to the preceptor for reassurance that what they are doing is '*right*', reference to this was made consistently throughout the study in comments such as:

'you want to be with the preceptor .. to build your experience, your practical experience .. and to make sure that you are doing that right so that you know

when you go on to the next stage .. you know that you've done that and you are doing it the correct way..' (18/5).

The preceptor therefore plays a very significant role throughout the student placements. As well as demonstrating 'caring' attributes the 'good preceptor' provides ongoing feedback and support allowing the student to develop and grow in competence and safe practice.

Influencing Factors

Specific factors influenced the role of the preceptor and the relationship formed between preceptor and student. As well as the environment which shall be addressed as a separate theme, access to the preceptor; workload and time are identified as significant influences.

Access to the preceptor

Shifts

Although each student has been assigned to a preceptor in every clinical placement, access to the preceptor was often limited for a variety of reasons. One of the main reasons was the shift patterns of the preceptor. In the early clinical placements it was not essential for the student to 'work shifts' and many chose not to because of personal or family commitments. Therefore, although the student was in the clinical placement for a minimum of thirty five hours per week, this was often between the hours of nine a.m. and four p.m., Monday to Friday. The preceptor, however, may have been working weekends, evenings and often rotating onto night duty. Many students chose to work the same 'shift' as the preceptor and others expressed pressure to do so:

'it is just you have to work shifts with them really to get to know them ..' (4/8)

Shift patterns will be explored further (page 142) when discussing the clinical environment.

Workload

Workload demands on the preceptors' time were often cited as causing a problem in gaining access. If the preceptor was a senior staff nurse involved in managing the care area, time available for direct care delivery with the student was often limited. The students were nevertheless sensitive to the conflicting demands on the preceptors' time in relation to patient care; documentation and administration as well as teaching and supervising.

Preceptor: Student Ratio

In addition to workload and clinical responsibilities, the preceptor student ratio is very important. The ideal preceptor student ratio is one to one. This ratio was achieved more consistently in community practice and was received very favourably with the students. The value of this is recognised in the following comment:

'When you are working with the preceptor, one to one, you really get to know them, they get to know you and it makes a big difference to your placement'

This ideal was not always realised. In some areas there have been up to three students to one preceptor and consequently less time afforded to any one student.

Time

Time spent with the preceptor in care delivery was a major issue for the majority of participants. It was not always the length of time however that was of importance, but the quality of time and interaction between the preceptor and student. The following comment reflects the view of many participants:

'sometimes they are very busy and they just don't have time .. but on saying that I've worked with preceptors who were excellent, I didn't spend a lot of time with them, but the time I did spend with them was quality time .. I actually had a preceptor and I think I only saw her on about three or four occasions in the four weeks but she was an excellent preceptor' (17/3)

Exploring this statement further with the participant, it was planning and organising that made the difference to the quality of the experience. The 'good preceptor'

negotiates with the student and plans a programme to meet the individual's learning outcomes. This was supported by another student who said:

'I learned a lot about nursing care, they were really good, excellent preceptors .. and I didn't spend every day, every shift with the preceptor, I knew what I was going to do, we planned it .. so she would go away maybe on four days off and I would know who my patients were going to be, I would know what I wanted to do for them .. I was allowed to plan' (6/25)

This issue of time and quality of time was raised frequently. Spending time was often considered as a reflection of interest and care for the student. Nehls et al (1997), differentiate between time in the linear sense and the existential sense when they say: '.. students were clearly concerned with linear time, that is having a sufficient amount of time to learn nursing thinking from a practising nurse. However, through the process of receiving time, the existential or ontological perspective of time as care emerged .. according to Heidegger 'to concern oneself with oneself or with others, to allow persons or things to matter, is the essence of time' (p.223).

Thinking about time in the linear sense the students in the current study consistently acknowledged the overall length of placement to be too short because it limited access to the preceptor and time to work with them. However in situations where the preceptor used the limited time to establish a relationship with the student, get to know them and plan the experience this proved to be qualitatively a more positive experience. It would seem that time was appreciated in the ontological sense and related to caring.

Preceptor Grade/Experience

The majority of preceptors were experienced nurses ranging from D grade (junior staff nurses) to G grades (sister/charge nurse). The grade and experience level of the preceptor seemed to have some influence on the student. While the majority of students found that the more junior staff nurses had more time to spend with them and could identify with their needs others commented on the value of the experience

of the more senior nurses. The type of experience to which the student is exposed may be influenced by the grade of the preceptor. When working with more senior staff the students could access more management type experience. However, more commonly the student identified positively with the less experienced staff nurses:

'.. quite a lot of the preceptors are high up, like the ward sister and they've got their paperwork to do .. two of my preceptors were in charge of the ward so you never really got to work with them .. but there was newly qualified project 2000 nurses and they were great .. they took you and showed you.. probably because they have been in the same situation, they understand what it's like .. they were really good' (18/18)

The majority of participants recognised a close allegiance with newly qualified staff nurses, they could identify with them and were more likely to discuss anxieties with them. The preceptor's experience of education also affected the student experience as observed in the following:

'I think if the preceptor is interested in education, interested in finding out .. the ones that are slightly better are the ones who are doing their degree or are studying themselves ... because they are involved in education themselves ... they are more interested' (14/31)

On describing a positive learning experience another student alluded to the preceptor's educational background:

'... but she is a degree educated nurse and she had an experience different from modular training nurses and could understand better .. their understanding of the course is different' (6/12)

Although this comment was followed up in subsequent interviews, only one other student supported this statement. The majority of students had either, not been aware of the preceptors educational background, or could not recall noticing any specific difference. Oullet (1993) in an American study identified that baccalaureate prepared preceptors provided greater professional socialisation for their students.

Negative Experience

A wide range of experience was discussed by the participants. While the majority of the experiences had a positive effect on learning, the negative experiences were

described in relation to the extent to which expectations were met. Once again the focus was on the characteristics of the preceptor. The 'bad preceptor', as perceived by the students, showed little or no interest in the student at all. Communication was minimal, often no introduction, and no attempt to establish a relationship. Consequently no rapport developed between the two. The characteristics identified earlier were either limited or absent. When the student was assigned to a preceptor who showed little interest, terms such as 'in limbo'; 'floundering'; or 'in the dark' were used to describe the experience. Similar terms were used by participants in Melia's (1981) study to describe the difficulties students experienced in situations where information was limited or denied.

A poor preceptorship experience seemed to have a greater impact on the student in the early course stages. They were less concerned in the later course stages when they had developed in confidence and ability to seek help in achieving learning outcomes.

Conclusion

The preceptor role is described predominantly as one of supporting student learning in practice. The participants clearly differentiate between those characteristics which contribute to their perceptions of both a positive and a negative preceptorship experience. A positive attitude towards the student and interest in facilitating learning are clearly essential. When the student is expected, welcomed and a planned programme is organised, this has a direct influence on role perception, they see themselves as a student and appreciate the learning outcomes and goals to be achieved. The preceptor who takes time at the outset to clarify expectations and discuss the aims, objectives, and goals of the individual student provides the basis for a positive learning experience.

In summarising, the students affirm that the success or failure of the preceptorship experience depended on the individuals and the quality of the relationship. The

preceptor's personality, attitude and values relating to nursing care all influenced the relationship between preceptor and student.

The dynamic nature of the preceptor role has become apparent throughout the data analysis. The level and type of support required initially by the student alters as they become more autonomous and require less direct supervision. The extent to which the role changes within a placement and between placements as the student grows and develops in confidence and competence will be further explored.

As well as contributing to student learning per se, a positive preceptorship experience provides a vehicle for the socialisation process of transition into the clinical environments, of becoming part of the team to which the student aspires to belong. This clinical environment and the process of transition is now explored as another major theme emerging from the study.

5.3 The Learning Environment

The second major theme generated from the data analysis was 'the learning environment'. Students are assigned to preceptors in a variety of health care settings from acute hospital wards to community and social settings. Hence it is important to interpret the findings in relation to the complex clinical environments to which the students have been exposed. It is also important to remember that when we speak of the environment in which the students and the preceptors interact we are speaking of a perceived environment, one that is influenced by the individual's past experience; expectations; values and perceptions of nursing. As such each individual student and each preceptor is likely to perceive the environment in very different ways.

While acknowledging individual perceptions of the clinical environment it is most important to take into account the diversity and complexity of the overall learning environment in nurse education. The context of learning extends from college to clinical practice, hospital wards to community settings as well as to a wide range of 'specialist' areas. Melia (1987) acknowledges this when she says:

nursing is an occupational group which comprises a wide and diverse range of personnel. The level of education, type of work carried out and the amount of responsibility shouldered by those calling themselves 'nurse' vary a great deal (p.160).

She goes on to suggest that this heterogeneity has implications for the development of knowledge and understanding of the group, nurses, as a whole.

The complexity and diversity of clinical areas and the implications for student learning must be acknowledged. Each area to which student nurses are assigned has different personnel; different patients; different work and work patterns; as well as different structures, goals, values and attitudes towards 'nursing'. It is only through exposure to clinical practice and interacting with people within these areas that the student learns how 'to be' a nurse and adjust ideals through reference to the reality

perceived. The student experience of preceptorship and learning in context will now be described.

Entering the environment

Recognising the diversity and complexity of the clinical learning environments, the participants express their anxiety and unclear expectations on going to any new clinical area particularly in the early course stages. The extent of the anxiety is illustrated by one student who described the experience of an early clinical placement:

'I was like .. walking into another ward and I felt like a complete alien .. I just didn't feel comfortable ..' (22/6)

This individual's experience was explored further and led to discussion regarding ways of preparing students for clinical practice and introducing strategies to reduce anxiety. The same student identified the need for support in:

'.. that was the main thing (support) that I really needed to begin with because I had never done any type of nursing at all before I started the course .. it was totally new to me, although I had always wanted to do it, it was totally new' (22/6)

The student perception of the clinical learning environment and the level of anxiety about starting a new placement was clearly influenced by past experience. Not only course stage but also previous experience of nursing affected the ease with which the individual entered a new clinical environment. Many participants had previously worked as auxiliaries and others continued to do so to augment the student bursary.

Commencing a new practice placement is undoubtedly an anxiety-provoking experience for most student nurses. Each of the participants identify the primary concern 'to be accepted' or 'to fit in' to that environment. What is evident is the extent of the concern and the implications this has for learning. The students clearly identify the priority of social acceptance over educational aims at the beginning of each placement. One student expresses this in:

'everywhere you go you've got to fit in ... it can be that they make or break any placement .. the response you get from the staff' (6/30)

Comments such as these are not new and the need for student nurses to 'fit in' to wards and clinical areas has been well established in earlier works particularly that of Melia (1987). Throughout Melia's work students referred to the need to meet the expectations of those with whom they worked and 'fitting in' constituted a major part of the student behaviour in that they concentrated their efforts on getting on with the ward staff before they were able to focus on patient care and learning from practice.

While Melia's study is now more than ten years old, and was carried out within a very different educational climate, the current research shows that such behaviours are still evident today. Participants highlight the need to 'fit in' before focusing on learning and delivering patient care:

'.. I think if you feel part of the team and you are included it makes you want to learn more .. I definitely think feeling part of the ward and part of the team and getting on with the staff makes a big difference to how much you are actually learning ..' (7/10)

Such is the need to 'fit in' and be accepted that the students tend to adopt strategies to ease the process. These strategies may be compared to 'teacher pleasing strategies' adopted by students in many educational programmes. The following comments reflect some such strategies:

'you go in and you try and you work really hard and you try to please everybody and sometimes you are not learning what you should be learning because you are trying to please' (6/6)

'I wanted to be part of a team and work within that team, you know get to know them, but I couldn't do that to begin with .. and then you just push forward and then you talk and then you start saying .. what do you do at night, things like that .. just starts the conversation going really ..' (21/3)

A number of students talked about trying to find out as much as they could about the area before going there. Other students talked about the importance of the nursing assistant to the fitting in process. On arriving at the ward, when the preceptor was

not available, one student said she would *'pick up a nice auxiliary and just follow her .. they know everything about the ward .. they seem to know how the ward runs .. ask her and she will tell you.'* These comments reinforce the priority of the student as getting accepted in the area, getting to know the staff and the routine prior to focusing on patient care and learning. This again is consistent with Melia who said: *'they felt it was important to get along with the trained members of staff and the auxiliaries, as well as with the ward sister. The constant movement from ward to ward demanded that the students develop a means of coping with and functioning within the system'* (Melia 1987 p.105).

Having a preceptor

While there are many similarities with the work of Melia (1987) there are also differences. One of the main differences focuses on the influence of having a preceptor. It would appear that the preceptor plays an important role in the fitting in process and to some extent acts as a vehicle for assisting the process:

'If you feel you are being invited or helped to be part of the team your placement is excellent. If you feel you are on the fringes .. that's not very nice .. I think that's where the preceptor can work in your favour .. if the preceptor invites you into the team there is more chance of the other staff accepting youeverything pivots round the preceptor because they're your first contact with the ward, they're the ones that sort of for the first couple of days is kinda guiding you into things and if they can accept you and feel happy with you .. you can see that sort of communicates with the other members of the ward staff and they can start accepting you in too' (8/22)

This is reinforced by another student who said:

'.. the preceptor will introduce you to the rest of the members of the team .. and they'll ask you questions .. what do you want to learn and then they can say right well so and so is doing that today, you could follow her or you could come with me and do this ..' (21/4)

Student role

Another major difference evolving from the current study is the students' perceptions of their role. As alluded to earlier, the students in Melia's study were prepared under a different educational system. They were employed under a contract of service to

provide care during their course of preparation and as such were seen as both worker and learner. The students saw themselves first and foremost as workers during their clinical placements. In the current study however, students are experiencing a different structure to their educational preparation, while on placement they are supernumerary to service requirements, except during the final six months of their course which constitutes the rostered service contribution.

Throughout this current study, when asked about their role in practice, student responses have been very varied. Even although they are now supernumerary to service requirements, in some areas they perceived their role to be that of 'a worker' and often used the term 'just a pair of hands', in a derogatory sense, to describe the experience. However, the majority of participants did see themselves first and foremost as students with particular learning outcomes to achieve. The extent to which their role was realised was influenced not only by the preceptor but also by the environment and the values and attitudes of the staff:

'It really does make a difference, the moment they show you like, this is what you need to do .. you really feel like a student and you know you have certain things to achieve .. it depends on attitudes' (11/5)

The Process of 'Fitting In'

A number of preconditions and influencing factors have evolved from the analysis which facilitate the process of 'fitting in' to the complex environment of nursing. Once the student feels part of the environment they can then focus on learning. These factors will now be described and the effect on learning explored.

Preconditions

‘Ambience’

Without exception the participants identify and discuss the importance of the ‘overall atmosphere and friendliness’ of an area to their sense of acceptance and ability to ‘fit in’. One student clearly links this to a learning environment:

‘I think what really acts as a catalyst to your learning is when you go to a place and it’s a friendly place and they put you at your ease right away .. the general atmosphere that has a great bearing ..’ (10/16)

This statement from one student is reinforced throughout the study. The majority of students talk about the friendliness of the ward and the staff and how this can make them feel more comfortable and reduce their initial anxiety. When discussing the atmosphere of the area this is often linked to the interpersonal relationships between the staff as well as the morale in the area. If there is friction among the team this transfers to the students and appears to influence the ease with which they are accepted or ‘fit in’:

‘I think .. if the staff morale is high .. when they are feeling good about themselves and the ward it makes a big difference.. where if you go in and the staff aren’t getting on and there is just friction, it makes a difference if the staff get on themselves and they include you..’ (19/20)

As well as the general atmosphere in the ward the students identify ‘approachability’ of the staff, as the main characteristic in helping them in any new context. They use the term approachable to describe the person with whom they can openly and freely communicate and who is receptive and friendly towards them. The following comment reflects the potential for problem prevention or solving:

‘I think the main thing is being approachable .. I mean approach the person who has a friendly manner .. so if there is a problem then being able to sort it out ..’ (2/24)

The participants tend to identify people whom they see as approachable and tentatively try to engage in conversation ... ‘testing the water’ to assess the kind of response they are likely to get:

'I think it's like ways of getting to know them, like approaching them and saying, look where does this go? How does this work? Just a way of getting to know them .. see how comfortable you feel like approaching them with things' (21/3)

Welcome

The initial interaction on arriving at a new placement is significant for the students. When they discussed the need to 'fit in' it was often associated with 'feeling welcome'. When the students feel welcome in an area this influences their level of comfort and subsequently the ease with which they fit in. The implications are evident in comments such as:

'..if you are made to feel welcome in a ward and they show you that they want you .. then it makes all the difference to what you contribute' (20/18)

While welcoming is most often perceived by the student as the responsibility of the preceptor, it is more important that someone acknowledges the students presence and introduces them.

'if it's not your preceptor there should be somebody there that welcomes you' (21/7)

These findings are consistent with those of Fretwell (1982) who attempted to describe and analyse teaching and learning situations in hospital wards. Fretwell's work identified the influence of the staff and the importance of showing interest in the learner when he/she starts on the ward.

Being Expected

The degree to which the student felt welcome in a ward was often related to whether or not they had been expected. Although there was a formal arrangement between the college and the clinical areas, as well as a baseline standard that all areas would be informed at least six weeks prior to a student's arrival, there were occasions when a breakdown in communication was evident such as that experienced by the following student:

'there was one placement ..ahm.. they didn't even know we were coming and .. I was just dumped on them really .. and you feel like .. oh no I'm a right burden here .. they're not preplanned for it, and then that can be dodgy as well .. it can be a bit sort of iffy at first .. it was quite iffy that first week ..'

(5/21)

The impact of the initial reception and the degree to which the student felt welcome often influenced their approach to the placement. This was supported by another student who said:

'first and foremost is if you get off on the right foot at the beginning, even if it's just the initial 'hello' I'm your preceptor and my name is.. what's yours? .. but if you are totally ignored then that can put you off at the beginning'

(13/40)

Part of the Team

Without exception the students expressed the need to become involved and feel like part of the team so that they could 'fit in'. Many declared the desire to become part of the team, and to work within the team. In order to achieve this feeling of belonging (to the team) the student must first become involved in the everyday work of the area. The degree to which they become involved has a direct influence on the 'fitting in' process:

'.. making me part of what they are doing and ehm .. it doesn't matter what it is, as long as you feel you're part of the team or you know you are made to feel welcome .. I think is one of the most important things .. which helps your enthusiasm as well .. I feel if you have fitted in quite well with the team then it helps you settle down how much they make you feel welcome ..ahm .. and involve you I would say is one of the most important things'

(5/37)

Reference to 'the team' was a recurrent feature throughout the study. Goffman's (1959), 'The Presentation of Self in Everyday Life', may be helpful to understanding the student perception of the team and the need to 'fit in'. He refers to 'the mythology of the team', in his analysis of interactions within social establishments. This seminal work of Goffman explores the dynamic issues created by the motivation to gain and sustain a part within the team.

Becoming Involved and Being Accepted

Becoming involved is not only related to the work that is going on in the ward but also to the social interactions. One of the main social activities is identified as tea breaks, and being included with staff at tea breaks is really important to the student's feelings of acceptance. Throughout the study being involved with staff at tea breaks was often discussed in relation to negative experiences and feeling 'like an outsider'. One student linked this to the process of 'fitting in' when she said:

'..small things make such a difference .. the majority of the wards have been fine and I've fitted in really well ..CCU was terrible ... it's small things like at tea time the staff would sit in the unit and have their tea and the student gets sent .. you come back feeling I'm not worth anything here' (14/20)

Reflected in this statement is the influence of 'fitting in' and 'being accepted' on self worth. While this demonstrates the destructive influence when the individual feels left out, the opposite effect is attained when the student becomes actively involved as described in the following statement:

'if you are treated well in a ward.. like you are encouraged and are brought into like the team .. you are part of the team .. that makes you feel good' (23/16)

This influence of staff within the clinical environment on student self worth was frequently addressed throughout the study is discussed further on page 201.

Having Someone There

The significance of being allocated a named preceptor was not underestimated by the students. Each of the participants expressed the need 'to have someone there' in a placement, a name, someone to go to should they need to. This individual, normally the preceptor, was seen as the main vehicle for helping the student fit in to the area:

'I think it's going to a strange ward and knowing that there is someone there expecting you to be there and it's comforting to know that .. that's the main thing having a name..' (7/2)

The importance of having someone there related not only to the process of fitting in but had implications for all aspects of the student experience 'having someone there' is in fact central to the overall study and shall be addressed in the final discussion chapter.

Influencing Factors

Preceptor

It is clearly evident from the data that the preceptor plays an important role in the fitting in process. What seems to be important is the fact that this is a formally structured role and it influences the student expectations when going to a new area. The students see the preceptor as someone who will help them fit into the area and often describe preceptors in terms of how well they meet these needs. The following comments are reflective of the perceived influence:

'the preceptor can help you fit in to the ward and make you feel part of the team'
(20/3)

'.. you tend to find if you get on with them (the preceptor) the other staff are more likely to be friendly with you whereas if you don't get on with your preceptor .. it's the other staff that work with her all the time and they are not going to take a student's side who is in the ward for two days .. although they'll no say anything you can feel the bad atmosphere, do you know what I mean?'
(22/13)

The perceived importance of the preceptor in facilitating acceptance by the team was apparent throughout the discussions. As a result students tried to establish a relationship with the preceptor, not only for direct learning support, but also to ease the process of 'fitting in'.

Student Characteristics

The influence of the preceptor in assisting students into the environment has been established. However, many participants also acknowledge their own personal characteristics and identify the way in which these may impact on the process.

Age

Age was identified by many students as a factor which influenced the ease with which they entered a new clinical environment. The more mature students (over the age of thirty) were consistently more likely to introduce this line of discussion. However, there was little or no consistency on whether this was viewed as a positive or negative feature. In fact, whenever introduced as a negative feature, further exploration usually illuminated more positive effects. This is evident in comments like the following:

'ehm .. I think being an older student it can be much more difficult if you have a preceptor who is like twenty two .. and you go in and they want to know why you're there in the first place ..' (6/3)

This same student contradicts this statement later in the conversation when she says:

'.. as I say everywhere you go you've got to fit in .. I think that being older .. that's an advantage .. in that aspect because you've got more experience of people .. and you know that you can take a step back and think .. oh well .. I think that age there helps you ..' (6/30)

The fact that the participants who mentioned age were usually mature students requires further deliberation. The work of Kite (1992) who looks at age and the spontaneous self concept may be of value here. Kite discusses the 'distinctiveness hypotheses' which proposed that self definitions are influenced by those aspects of self which make us different from the majority. She goes on to support the hypothesis that students of non traditional college age, who are a minority in this dimension, should be more likely to mention age in their spontaneous self descriptions than students of traditional college age. '.. according to the distinctiveness hypothesis, defining oneself in terms of age should depend, at least in part, on whether one is unique on that dimension relative to one's environment' (p.1829).

From the current analysis it may be that mature students in nursing see themselves as being in a minority group, albeit there is a growing number of mature students entering nursing. The majority of new staff nurses are still likely to be in the

younger age groups and this may impact on a mature student's self image. If this is so, the suggestion by Kite that when people are unique on the dimension of age, it may impact upon their perceptions of and performance in academic settings, is an issue of relevance here.

The expectations and demands of the mature student appear to be different from those of the younger student which in itself may influence the response by staff in the clinical areas. This is supported by Meng and Conti (1995) who identify the frustration experienced by preceptors when they were paired with older graduates who needed more time than younger novices to adapt to clinical demands. These authors assert 'the older nurse appears to respond more slowly than the younger nurse. This is because the older nurse has filed a wealth of life experiences in a large number of 'brain files'. Therefore in processing new information, the nurse must search multiple files to relate the situation to past experience' (Meng and Conti 1995).

Personality

'Personality' was perceived as another major factor influencing the process of fitting in to the clinical environment. Many participants made reference to aspects of their own personality which helped them, for example:

'I'm quite chatty and I can get on with most people ... helps me when I'm dealing with .. going to different wards, because in four weeks, really the first week, you canny take the full week to fit in .. and I'm quite a chatty person so I learn to fit in quite fast, you know so that helps me..' (8/9)

While many students talk about their own personality many more speak of the preceptor's personality as an influence on their fitting in process:

'.. you built up a good relationship I think from meeting them from day one and they were there at the end but a lot I think has to do with personalities as well..' (7/5)

This student speaks about personality not only in relation to the fitting in process but also to the relationship formed between preceptor and student. Another student acknowledges the importance of personality in:

'to me my first priority is their personality, if they are willing, if they are friendly and approachable .. and I think .. an interest in teaching you .. and passing on to you .. they've got to have an interest' (12/21)

In addition to personality, this student identifies the specific characteristics he associates with the preceptor.

As well as to 'personality', the majority of the participants made reference to the influence of the 'attitude' of the staff to the process of fitting in. As discussed earlier, many of the comments related to attitude were linked with the student perceptions of the staff interest and enthusiasm for having students in the area. When describing negative experiences the attitude of the preceptor and staff is often referred to, for example reflecting on a particularly bad experience one student said:

'I've always felt and still feel that attitude and communication are the two main things that the preceptor has to look at .. attitude because it really can destroy a student ..' (8/34)

Another student highlighted the responsibility of individual students to be aware of their own attitude and went on to say:

I fitted in because I wanted to fit in .. because I wanted to make the most of it .. and I think that if you made the effort then they were quite prepared for me to do what I wanted to do .. and it was just so different .. it was great' (6/26)

These comments reflect the many references to personality and attitude which influenced the preceptorship experience and in particular the process of 'fitting in' to the clinical environment.

Gender

Few comments were made regarding gender and these came exclusively from two male students. One commented on the difficulty in fitting into the maternity placement:

'.. I'm no being sexist but I felt the females got a lot better reception than we did.. ehm from a lot of the staff ... I think it was probably down to it being maternity ahm.. I think they were a bit more embarrassed than we were' (8/8)

The other student commented on his first community experience:

' the previous preceptor I had was a sister on the district.. she was a bit older and didn't know what to expect from me .. especially being a male student, I think ..ehm .. kind of cushioned me a little bit from a lot of things..' (12/13)

This same student went on to refer to gender once again in:

'yea and again another bad experience I had was another male as well .. I don't know whether it is the gender thing as well .. it was two guys and twice ... two of the biggest problems I've had have been with two male preceptors' (12/13)

The only reference to gender was made by male students. While these comments were raised spontaneously identifying what appeared to be a very important issue, further enquiry in the subsequent interviews, with both male and female students, failed to support the concerns. Once again the 'distinctiveness hypothesis' may be relevant to this issue given the minority situation of men in nursing.

Course Stage

The student's course stage would appear to have a strong influence on the process of fitting into a new environment. In the early course stages the students tend to feel more anxious and in need of more support. The lack of experience as well as lack of understanding of expectations tend to heighten this anxiety. The students to some extent see themselves as observers in the early experience and this is also reflected in the expectations of the staff. However, this in itself causes confusion and conflicting expectations, because while the students see themselves as an observer their aim is to

become involved, to be doing things and to be treated as a member of the team as identified above. Given the lack of experience of the student, staff expect very little in the first placements and are therefore caught between demonstrating, supervising and supporting the student and getting their work done.

Expectations

As identified earlier the expectations of both students and staff influence the 'fitting in' process. To some extent this may explain why the students in the early course parts have difficulty in 'fitting in', they don't know what to expect from the staff, the patients or the environment. At the early course stages the students are still busy trying to reconcile their own perceptions of nurses and nursing with their new experiences of the reality of practice. As the students develop they become more aware of the 'general' features of the environment and begin to focus on the specific when going to a new area. They have a clearer idea of what is expected from them and they will have developed to some extent their own strategies to help them 'fit in'. Once again this highlights the need for good communication between the staff and student, particularly in the early stages, and the importance of providing opportunity to clarify expectations at the outset, a need expressed by the majority of participants in this study:

'.. and I think initially we should sit down and discuss ... what's expected of the person because you go in there and you never know what they expect from you and then they know what you can do and you know what they want you to do ..'
(6/33)

Previous Experience

Another factor which influences the process of fitting in is previous experience. When the students had been exposed to similar previous experiences they had some idea of what to expect. One student who had worked as a nursing assistant for many years expressed the influence of her previous experience in:

'care of the elderly I'm in just now and I'm quite comfortable going in there .. I knew that was going to be no problem to me because I've did it for so long...'
(15/39)

Interestingly enough comments about previous experience were made more often by students who had no previous experience of nursing. This in itself requires further deliberation as it impacts on perceptions of self image and comparison with peers:

'.. and there was a lot of girls in the class who'd been care assistants or auxiliaries .. and they had something to relate it to whereas I felt as if I didn't and I think that was quite difficult .. it was hard to take in .. then when we went out on the ward I felt as though I had been thrown in at the deep end ..'
(3/20)

Another student highlighted the influence of previous experience and linked this with the issue of short placements:

'... it was only like the second time I had been in a ward .. I had never worked as a nursing auxiliary and it was all quite new to me, four weeks isn't enough time to familiarise yourself with a ward and be comfortable in it..' (22/4)

Length of placement

Almost without exception the students referred to the length of placement and recognised how this affected the process of 'fitting in'. The majority of placements throughout the course were of four weeks duration until the latter course parts when they were increased to five, six and ten weeks. The ten week placements occurred in the community setting and constituted part of the rostered service contribution. The following comments illustrate the student views on the length of placement:

'it's difficult I think especially with the length of time you're in a placement, you are there four weeks .. you are just starting to get to know the staff or getting to know where everything is and getting to know the routine when you are away again, so I think that's quite difficult'

'four weeks is too short .. it takes a wee while to settle and become confident about what you are doing as well .. and confident about eh ... you know, working with the other staff .. and that worried me.... I don't know whether six weeks would be a better period of time to be there' (25/5)

'I think you are just getting settled in .. you are just settling down when it is time to leave again'

Without exception the students expressed the view that the majority of placements were too short to maximise their learning. Melia (1987) has previously highlighted the problem of short placements and acknowledged the effect this has on student behaviour and learning: 'the emphasis which the students themselves placed upon 'fitting in' and 'getting through' demonstrates the fact that the three years are seen in terms of short spells in different clinical areas with constant awareness of the next move' (p.174). More recently Hamill (1995), explored the phenomenon of stress as perceived by Project 2000 student nurses and identified short clinical placements as a source of stress in student nurses.

Most of the comments about length of placement in the current study were related to institutional placements. The community placement was different in that the students spent four weeks with the district nurse in course part five and returned to that same district nurse in part six for ten weeks. The difference is recognised in:

'it's really quite good, as I say the month that you come before you're actually rostered service really does help as far as the community's concerned .. because you get to know everybody and it puts your mind at ease for coming back again ..' (21/14)

This comment reflects on the structure of the community placement and illustrates how not only the length of placement but also continuity of placement impacts on the fitting in process.

Continuity

Many students make reference to the impact of continuity of placement, this was explained by a student who said:

'(going back to the same place) .. it makes it much easier for you, because you are so much more at ease when you go back, they know you, and you know them .. the initial walking in somewhere and taking you two weeks .. before they even remember your name ..' (6/13)

Not only is continuity important to 'fitting in' but also to the process of learning from practice. The influence of continuity on learning is therefore explored further on page 169.

Shift Patterns

Continuity of experience is also influenced by shift patterns which have already been addressed in relation to the preceptor student relationship. However, the majority of participants suggest that to be accepted and to fit in to the ward they had to 'do shifts'. It was only by working the same duties as the rest of the team that they could get fully involved and feel like part of the team. It is also suggested by many students that there are feelings of resentment from the staff who question their motivation towards nursing if they do not work shifts. This is reflected in the following account:

'well if you go into a ward initially you can work nine to four because it's college hours .. they just hate that .. fair enough it's not reality in the nursing situation, but when you go into a ward and you say well I only have to work nine to four .. oh do you know they just hate you for it, they really do and you can get such bad vibes from them because they think you don't really want to learn anyway so what is the point .. you know if you are coming in at nine o'clock all the work is done How can you learn anything if you are not there to see it in the morning? ...'

(6/28)

Type of Placement

In addition to shift patterns, considerable reference was made to the type of placement and how this influenced the fitting in process. The students involved had experienced clinical practice in a variety of different areas. In the first eighteen months of their course they had come through a common foundation course preparing for entry into either the adult or mental health branch. Placements within the first eighteen months included acute general wards, mental health, care of the elderly as well as one community placement with the health visitor. In the branch programme the placements were specific to the chosen branch either mental health or adult nursing. A more extended community placement was included in the branch programme. Throughout the interviews it was clearly evident that the type of area influenced the student experience. Major comparisons were made between adult and mental health placements in the common foundation programme and between ward and community placements in the branch programmes.

Adult / Mental Health.

Although the students were involved in a common foundation programme the choice of adult or mental health nursing was established prior to course commencement (a manpower planning requirement). What was established at the first interview, and confirmed throughout, was that this choice influenced the student experience in a clinical area as well as the extent to which they 'fitted in'. The following quotations aim to reflect the student perceptions of the influence of their branch choice on either mental health or adult placements:

'the time I went to the mental health placement I was part three .. I was still adult branch and I think they seemed to be more interested if you were doing mental health, they were only interested in spending time with you if you were mental health rather than adult, I could be wrong but that was my impression...they seem to be more interested in the mental health branch than the adult' (3/17)

This comment by a student who would be entering an adult branch programme was confirmed by a student who would be proceeding to mental health:

'(mental health student) .. I was with somebody who was doing general at the time and it was as if they were more interested in the general student than they were in me... it was as if there was stigma attached to you doing psychiatric nursing, whereas I don't know if the generals will say the opposite.. but I found in psychiatry because you were intending to do psychiatry they were really interested in showing you as much as possible.... when I was in psychiatry I seemed to learn more' (1/4)

This student alludes to experience in general placements, and is supported by others in comments such as:

'are you doing general or are you doing psychiatry? As soon as you say psychiatry .. oh well you'll probably no really be interested in here' (8/4)

Many opinions were expressed regarding experiences specific to mental health and adult placements. Although the students were interested in accessing the widest experience possible they felt the preceptors and staff didn't involve them to the same extent because they were not pursuing, and therefore deemed not interested in, the particular speciality or branch. When they were in a placement that was related to

their branch choice the students seemed to become more involved, their interest in the area as well as the interest of the staff seemed to have a positive effect their learning. Overall this influenced the extent to which they felt they 'fitted in' to the area. The students who were undertaking the mental health branch all commented on the mental health placements as being more friendly, more flexible and the preceptors had more time to spend with them. Those undertaking the adult branch highlighted the different experiences in acute areas such as medical, surgical, care of the elderly and critical care. The workload and staffing levels in these areas influenced their access to and time spent with the preceptors, factors which also influenced the overall atmosphere and the extent to which they 'fitted in'.

Specialist areas

Adult branch students were often placed in 'specialist' units such as coronary care or intensive care for experience. This again had implications for the process of fitting in. Two students who had been to a Coronary Care Unit commented on the difficulty in fitting in to such a specialist area.

'as a student in a coronary care ward you are totally .. well I thought totally out of your depth .. it took me to about the fifth week before I felt .. kinda comfortable in it ..' (14/7)

This feeling was confirmed in a later interview:

'I was in coronary care, which is a very small unit and I felt it was .. and I've also been to A and E .. and I felt it was quite cliquey ...both of them ... because there is not a lot of staff, they have been there for years.. but they don't .. like a lot of other areas maybe two go for tea and maybe get out of the area .. they never, they always seem to stay in the area, they don't get out, they don't seem to mingle ... plus they are more advanced as well' (19/18)

The students often found it more difficult to fit into smaller specialised units. Further probing within the interviews discovered that this is often due to the 'specialised' knowledge which they don't as yet have access to as well as their perceptions of the staff being a very cohesive group to which they could not aspire to belong.

Midwifery

The midwifery placement was another area where 'fitting in' was difficult. This was attributed not only to the specialised nature of the practice but also to the number of students seeking the experience:

'.. we were left to get on with it .. especially in that .. in a setting like maternity .. ehm .. you were in the dark there anyway because of that kind of setting .. specialist .. there wasn't much we could do anyway .. we're not midwives ..' (12/3)

The difficulty experienced during the midwifery placement was due to many factors. Not only is the nature of practice very specific, but also the placement arrangements were different from others. The restricted availability of midwifery placements resulted in a greater number of student nurses going for a shorter period of time. It was not therefore possible to assign each student to an individual preceptor during this experience.

Strategies

Such was the need to fit in to each new environment that students adopted strategies to ease this process. They discussed among their peers and tried to find out as much as they could about the staff, the preceptors and the general attitude towards students before going to any clinical area:

'before you go into any placement you always get the run down from the students before anyway, what to expect .. so you are going in with an idea of what to expect anyway ..' (5/5)

Once in the placement the focus is on making an impression. This often involves taking on the worker role, and terms such as '*pull your weight*' and '*work as hard as you can*' in order to please are used by participants. As already highlighted, the effect of continuity is recognised and students often request to return to the same area for more senior practice placements:

'I went there at the beginning of the year and I asked to go back simply because it was continuity..' (6/11)

Consequences

It is clear from analysis that when students feel they are accepted and 'fit in' to the clinical environment the consequences for learning and development are very positive. The social needs of being accepted and fitting in are therefore the students priority at the beginning of a new placement:

'people are still sussing each other out .. you're still getting used to the placement, fitting in .. so maybe after a week .. you know five days is long enough to get used to a layout .. it's long enough to sort of find out where you both stand and everything, I think and then it's down to the nitty gritty, you know..'
(16/13-14)

When the student feels as though they 'fit in' to an area they are much more relaxed and comfortable and therefore more free to ask questions, respond to challenges and focus on learning. They are more likely to seek support and advice and are also more receptive to feedback and critical appraisal. This is reflected in the following statement:

'I think it does make a difference .. if you feel you fit in to the ward then I think you are going to gain a lot more from it .. whereas if you feel left out of it .. you might .. your motivation is not going to be there and you .. you just wouldn't want to go .. so you are no going to be motivated and want to learn or .. so I think it does..'
(19/17)

The feeling of 'fitting in' and as such being accepted as an individual has a direct influence on the students' self image. They feel appreciated, valued and have an increase in self worth and self confidence. This would appear to have an effect on performance:

'.. you were made to feel as if you were part of the ward ehm .. you were welcomed, every time we went off duty it was always like, thanks very much ehm .. for your help today .. and it really made you feel as if you were worth something it helps you to learn as well because it gives you confidence and the more confidence you've got .. the more .. well I think .. the more you are going to learn I think if you're not confident and you don't feel you are part of the .. like team or whatever.. or part of the ward .. I don't think that's a good learning environment .. I don't think you're going to learn as much ..'
(14/22)

As well as positive experiences, many students describe circumstances where they don't 'fit in' to the area. As one may expect, this has a negative effect on self image and self esteem. The participants express feelings such as 'useless', 'ignored' and describe how throughout the placement they often 'tag along' with whoever they can.

The fact that self esteem and personal efficacy are tied to performance in the work setting is well recognised by Demo (1992) in his analysis of research into the self concept over time. These findings are also consistent with the work of Carl Rogers (1969) who recognises 'acceptance' as one of the characteristics of the facilitator who creates a climate for learning.

Summary

Participants in this study highlighted the need 'to fit in' to the complex and diverse environments to which they are exposed for nursing practice and experience. At a personal level this involves being accepted, included as part of the team, valued as an individual and trusted to contribute to patient care. The need to 'fit in' appears to take precedence over educational and learning needs. Only when feeling settled and comfortable in the environment can the student focus on learning. This finding is supported by others, for example Melia (1987), and more recently by Nolan (1998) who advises that until students feel accepted, learning cannot proceed, as fitting-in takes up most of their time and energy. Wilkinson et al (1998) also suggest that students engage more completely in those situations in which they were made to feel a part and that being treated as 'part of the team' helped the students establish identity not only as nursing students but as nurses.

The conditions necessary for 'fitting in' have been recognised and the main factors which influence the process have been outlined. However, as well as the need to be accepted within the clinical environment the participants acknowledge a range of needs which influence learning. Student needs will now be analysed further prior to

exploring the influence of the preceptor, the environment and the student on the process of learning.

5.4 Student Needs

The student perceptions of the preceptor and the environment have been described. The next major theme to be analysed is 'student needs'. Reflecting on the experience of preceptorship the participants discuss a complex variety of perceived 'needs' which are clearly linked with their expectations of the preceptor and clinical practice. Without exception the participants identify 'support' as the most important requirement from the relationship. However as they develop the need for challenge is recognised as essential to learning.

Preliminary Needs

From the previous discussion it is well recognised that on commencing any new placement the student feels the need to be expected, welcomed and introduced to the staff in the area. The preceptor plays an important role in meeting these needs. It is important to get to know the staff and patients and to clarify expectations before focusing on learning. Clarification of expectations is perceived as an important part of the preceptors' role and essential to the learning experience:

'I think at the beginning that's what you need .. just somebody to sit down with you for fifteen minutes and say .. right this is the ward, this is what we do .. what do you want? What are you hoping to get from it? .. that's all it takes just somebody to sit down and speak to you' (14/29)

Learning Needs

The aim of each placement is to learn the practice of nursing and the need to set achievable goals is recognised by the participants. Jones (1981) identifies the need for goal setting in nurse education. She refers to the substantial research demonstrating an increase in the motivation level of the student through setting specific goals of learning. While recognising the need to set goals, the students within the current study identify the need for help in identifying and setting realistic goals specific to the area and relevant to their course stage. Although aware of curricular learning outcomes to be achieved on commencing a new placement,

knowledge of the specific experience available is limited. The students look to the preceptor to identify the experience available, to advise on specific objectives, and to provide a structure within which this may be achieved during the placement.

Structure

The need for structure to the placement has clearly emerged from the data. Many participants highlight the impact of structure on the process of learning. The availability of a structured programme helped the student to focus on learning, recognise opportunities, and achieve predetermined goals. Although not always available, when the preceptor had a programme for the student this provided a vehicle for discussion, allowing expectations to be clarified and achievable goals to be identified and set. As previously stated, when this happened it clearly influenced the student's own role perception. They 'felt like a student and knew what they should be achieving'. The advantage of this is expressed by a student who said:

'I found it helpful because I knew what I had to do, what I had to accomplish .. you know it was like ticking off, I've done that, I've been there, I've seen that .. it was something to sort of measure yourself by .. because sometimes you can go through and you can think I don't know whether I'm doing .. do I know what I'm supposed to know? .. am I doing what ... it's very difficult to judge yourself' (17/8)

Having structure to the placement allows the student to recognise the experience available and to some extent measure progress in relation to achieving specific goals.

Daloz (1986) recognises that anxious students need considerable structure and guidance, especially when they have been away from study for years. Clear expectations as well as short and achievable tasks are important for such students. He goes on to suggest that for many students a high degree of structure may be supportive at first, however depending on his/her specific learning style each individual will require and respond to different levels and degree of structure.

The changing need for structure is recognised in the current study. As the student progresses and becomes more confident in identifying personal learning objectives,

the need for structure alters. The views of the majority are reflected in the following quotation:

'I found it very helpful (having a plan) .. you knew what you were going to be doing .. especially at the beginning. With the health visitor I had a plan made out for every day .. I knew what I would be doing and what was expected ... it was helpful but now that I am further on there is not the same need for it. In this placement you don't know what you will be doing but you will be involved in everything that the rest of the team are doing ..' (24/7)

This student highlights the importance of structure in the early practice placements but recognises the need to learn to practice as a full member of the team, with little evident structure, now that she nears the end of the course. Structure in this way may be seen as a support for the student, something they need to help them progress but also need to 'let go' of, or become less dependent upon, as they become competent practitioners.

It is clear from the data analysis that students seek structure in learning how to practice in the clinical setting. The level and degree of structure needed depends on the individual, the course stage as well as on previous experience within the area.

Guidance

As well as identifying the need for structure in relation to learning, the students also identify the need for guidance, participation and support in delivering patient care. What emerges is the need to observe the experienced nurse carrying out care and to be allowed to participate in the care delivery. Guidance is recognised in the form of verbal and non verbal interaction. The effect of observation alone is limited. While participating in nursing care, the student looks to the preceptor 'to talk through' and explain what he or she is doing; then allow the student 'to do' with the preceptor talking through and giving feedback on performance. It appears to be the verbal interaction of 'talking through' the activity or procedure, with appropriate and specific non verbal cues, which allows the student to develop a greater degree of understanding and of skill. This interaction is valued by the student not only when

they are actively engaged in the procedure but also when the preceptor is performing the procedure. This is reflected in comments such as the following:

'say like, aseptic technique, you would have been taught that in college but it's completely different when you are out there. So the preceptors ehm .. make sure that you understand it better .. went through it a few times with me .. which hand I was using .. 'cause you tend to get mixed up to start with .. taking the wrong hand and using the wrong forceps .. but showing you and standing there with you while you are doing it .. making sure that .. not picking holes .. you know it helps if they don't stand and say oh .. you are not doing that right .. you know .. but just talk you through it and say .. no that's better .. just talking you through is a wee bit better.. even injections' (4/17)

Another student acknowledges the importance of verbal communication with observation in the comment:

'.. that's really what you need .. to explain things to you .. I think sometimes they can feel that if they show you something that's excellent .. it's the explanation you need' (8/9)

Participating in care delivery with dialogue, support and supervision from an experienced practitioner helps the student bridge and make connections between what they know and the new experience. The work of Rogoff (1990) suggests that actually participating in the activity involves a stretch in the direction of a more mature definition of the situation and a more skilled role. It is evident from the current data that dialogue between the student and the preceptor realises the potential for collaboration and sharing of meaning. The extent to which this influences a resulting extension in understanding shall be explored further in the section describing the process of learning (p.176) as well as the final discussion chapter (p.221).

Support

The need for support has been clearly evident throughout the previous section. What has been described so far is the students' expectations and experiences of support from the preceptor, particularly in relation to 'fitting in' to the environment. However, further analysis highlights the different ways in which the individual

students interpret and describe 'support'. It is therefore important to explore the issue of support further.

As well as describing support in relation to interpersonal communication and advice, many students link support with safety. In the early course stages the student needs 'to be kept right' to be assured that they are doing no harm and to feel safe. At this point in time they need a great deal of support and discuss this in the form of supervision and reassurance:

'.. (you want) .. them (preceptors) to supervise you .. well at the start to supervise you while you are doing things .. to make sure that you are doing the practical things right ..' (18/4)

Supervision was therefore perceived as 'supportive' when it influenced the students' level of confidence, as described in the following quotation:

'it's confidence building 'cause at the end of the day I can say .. I've done that .. I've been able to give an injection .. it's simple things like that .. I've been supervised doing it and there was no problem' (2/25)

While the need for supervision diminishes as the student progresses, the need for reassurance regarding safe practice continues throughout the course. Describing a placement at the end of the course, one student said:

'I was still going to the preceptor or other members of staff .. just to cover myself .. to make sure I wasn't doing anything wrong and I wasn't going to harm anyone in any way at all' (3/4)

As the individual develops, the need for reassurance of safe practice continues and is often sought through feedback on performance from the preceptor. The importance of guidance, and knowing how to do things 'correctly' throughout is recognised in comments such as the following:

'now (near the end of the course) you are looking for a different kind of guidance, as I say you are looking for more reassurance .. because you know what to do now and you'll go ahead and do it .. but you want to make sure that what you've done is correct ..' (12/11)

Type of Support

Different interpretations and perceptions of support are described by the students in relation to specific contexts and course stages. Further data analysis highlights the complexity of the concept and distinguishes two main types as 'personal' and 'professional'. Personal support is described and discussed by the students in relation to social or emotional issues while professional support is related mainly to learning and development:

'you need support, both professional and personal .. emotional support ... well professional support to make sure you are learning what you should be learning, meeting your goals, getting experience .. and personal and emotional support because you are in situations that are new to you and you are not sure what you should be doing. Also in things like making sure you get a tea break ...'

(24/6)

Personal and Emotional Support

Personal or 'social' support is most often described in terms of the help the students require to 'fit in' to the clinical placement areas. However, emotional support is more frequently recognised and described in relation to 'critical' or emotional incidents. One student describes a positive experience of support following a traumatic incident:

'you need personal and emotional support .. because you are seeing things .. you know I had a hard time in ehm .. the death of a baby .. in maternity .. and I found that very difficult .. I found the support from the staff then excellent, you know because they knew I had never dealt with anything like that before .. they were all great and they all spoke to me and you could go and speak to them if you wanted to .. yea .. personal support is very important'

(21/6)

The need for emotional support is well recognised in the nursing literature. Smith (1988/1992) describes nursing work in terms of emotional labour and identifies the need for support. Hutchinson (1984) explores the stressful environment of neonatal intensive care and identifies the strategies which nurses use to create meaning allowing them to cope with such stressful situations. Not only is it important that nurses recognise the need for emotional support in the student but also that they

demonstrate and share different strategies for dealing with emotional stress in their everyday work.

Critical incidents for the student, however, are not always related to death, dying or the unexpected emergency. Depending on the student's past experience, any situation could prove to be 'critical' for an individual therefore getting to know the student and establishing a relationship within which he or she can express themselves is essential for the successful preceptorship. One student recalls his first ward experience as a situation in which he felt unsupported and described the resulting emotional disturbance in the following reflection:

'I was kinda hoping she (the preceptor) would take me under her wing ... walking into the ward I felt like a complete alien .. I've never been in hospitals before through illness or anything like that .. the only time I had ever been in a hospital for any sort of .. recurrent period was when my gran was ill with cancer and I was only a wee boy and I can remember .. it all being sort of .. go in and have a wee look but I wasn't allowed to speak to her or anything like that .. and I remember noticing the smell .. it's funny because when I went into that ward for the first time it was the smell I noticed, the hospital smell .. I thought oh God .. I just didn't feel comfortable .. I took myself into the wee cloakroom and said .. just compose yourself .. they'll help you out and all that .. and I remember saying to her .. look I feel a wee bit uncomfortable here, I've never really been in a hospital before I was hoping they would just kind of look after me .. be nice to me ... See that first placement see if I had learned nothing, see if someone had just been nice to me .. take it easy, it's your first placement .. if they were just reassuring with me ...' (22/7)

This student went on to discuss the resulting dilemma of whether or not to continue on the course. Through this discussion he illustrates his expectations of support from the preceptor. His vision of nursing as a caring profession had been altered by this experience in which he felt unsupported.

The support which students experience can influence the decision to continue in nursing or to leave. Ray Field, a director of nurse education, recognises this in a recent article in which he states: 'From my point of view, as a senior nurse, all students must be made to feel welcome during placement and must be cared for as

individuals. If nursing students are treated with respect and courtesy in their novice years they might just want to stay in their expert years .. if nursing students are not treated well and given the support they deserve and need, they will vote with their feet' (Field, 1998).

Support and Challenge

The need for support is clearly recognised by each of the participants and described in terms of reassurance, communication and reducing anxiety. However, further analysis identifies a dynamic situation where the need for support and the type of support needed alters as the student develops. A dialectic between support and challenge is evident. This dialectical situation appears essential for learning, to extend the boundaries of knowledge and skill and allow development to take place. This is highlighted in the following comments:

'sometimes you were afraid to do things but they would say it's all right I'll be there you can do it .. so you would do it and you would feel really good, I can do that .. that really helped your confidence ... they encouraged you'
(24/3)

This is reinforced by another student who said:

'they are supportive in the way they at times push you into it .. I said I haven't really done anything like that .. I think it makes a big difference when you are actually doing it and they are there for support and guidance ... (I thought) I'm going to be a nurse ... this is taking me ages, but she was dead supportive because she said look .. this is OK .. just take your time and you'll get there ..'
(1/14)

The balance between support and challenge is recognised in the following statement:

'.. the preceptors I've had have been keen for me to do things and they've kinda egged me on to do it and said, come on you can do that no bother .. on you go ... Even if I've been nervous I've always said .. I want to do it .. but they have egged me on ... They are kinda giving you the option of saying no, but basically they are telling you .. go and do that .. and I see it as a challenge'
(22/17)

The need for support was spontaneously and clearly identified by the students during the interviews. However, it was often after further probing, resulting from the constant comparative analysis, that the influence of challenge was recognised.

Challenge

The need for support and challenge throughout the whole course is evident. Furthermore, predominance of one over the other changes, to some extent within each practice placement, and to a greater extent over the course as a whole. The need for support is described as predominant in the early course stages, but as the student develops in confidence and competence the need for challenge is recognised more positively. The need for challenge from the beginning, or first clinical placement, is reflected in:

'I think even in part three you should be pushed by your preceptors .. in fact I think even from your first part, I know you might come back and say, my God that's my first time out .. but you've got to start somewhere ...' (15/4)

The recognition and response to challenge in the later course stages is described by another student who said:

'before .. you were like part of the team ... what I've found this time is you take .. the red team or blue team or whatever .. so it's about responsibility .. now that's the challenging thing that I see .. If .. at the end of the day I can provide my patient care .. and there is no sort of problems with that then I know I'm doing .. what I've been spending three years training to do .. it's the challenge thrown to me by my preceptor, I've sort of fulfilled .. and it's rewarding ..' (16/18)

This theme is elaborated upon, and the need for balance between support and challenge in the development of skill and competence is recognised by a student who explained:

'I don't think any student would mind being challenged and pushed if they felt prepared for it .. it's being thrown into a situation that you think .. I don't know how to handle it I would rather you were there .. even if I had to do it myself I would like someone there in case something goes wrong .. sometimes you have to push yourself .. because you would rather avoid it and you think

*.. I'm going to have to do this ..I would rather do it as a student than do it ..
you know as a new nurse .. in the ward..'* (17/12)

The positive effect of challenge is often recognised only on reflection as explained in:

'I remember my very first preceptor .. in orthopaedics .. I felt as though she was gi'ing me a really hard time, but looking back on it now she wasn't .. she was asking me questions every day and if I couldn't answer them she was like that .. I want you to go and look that up and I'm going to ask you again .. I felt she's gi'ing me a really hard time .. but now looking back on it the things she taught me are things I'll never forget .. which seem silly now but it was just little things .. that I'll never forget them now .. so that even although initially I thought she was giving me a tough time, now I look back on it, it was a great learning experience for me ..' (3/5)

It was only on reflection that this student recognised the value of a particular situation and changed his appreciation of what had occurred. Another student related a similar account of feeling negative about an experience which he later came to recognise as a learning situation. This student identified the challenge of working on a busy surgical ward and the responsibility of looking after a number of patients:

'it was just too much .. but I learned by it .. I thought well I've learned how to look after fifteen patients .. prioritising care as well .. looking back on it .. reflecting on it, it was really good experience .. at the time it was a lot of pressure and I felt it was unfair ..' (12/18)

Many of these situations, retrospectively recognised as positive and challenging, appear to have induced a degree of stress in the student. At the time of the incident they had been so caught up in the emotional discomfort that recognition of learning was limited. Only on reflection could the student recognise and deal with the emotions and separate the negative to focus on the positive thus realising the extent of learning which has occurred. The intensity of emotion is recognised in the following comment:

'I mean when I look back it was a good learning experience .. it didn't seem that way at the time because you kept thinking .. you were terrified' (18/4)

Although feelings such as fear and anxiety are induced, the personal satisfaction gained through responding to challenges is reflected in the following response:

'sometimes you would be afraid to do things but they would say .. it's all right I'll be there, you can do it .. so you would do it and you would feel really good .. I can do that, that really helped your confidence ... (the preceptor) .. they encouraged you .. yes they did .. when you went and done something you felt marvellous .. they always asked you, how did you feel about it' (24/3)

These comments highlight the need for challenge balanced with a supportive relationship in facilitating learning. Challenge is recognised not only through involvement in new and more complex activities but also through the process of interaction and questioning which shall be explored further on page 181.

Although questioning as a strategy is addressed later, the manner in which the interaction takes place is relevant here. While some preceptors' style of questioning is identified as stimulating and challenging, that of others is seen as threatening. This depends on the manner in which the questions are asked and the relationship which is established between the preceptor and student. This is acknowledged in the following comment:

'I suppose it depends on the preceptor .. there are some preceptors that you feel threatened by and if they start to question you .. because you know that they are going to .. I had one preceptor that everything I said was wrong, you know it didn't matter what I said everything I said was wrong .. even if I took a piece of research to back it up, it was wrong .. so some preceptors do threaten you but other ones .. they don't, they'll just say if you don't know the answer just .. you can leave it and you can read up about it and you can talk to me about it at a later stage which is great because you don't feel as uptight about it ..' (21/8)

The significance of questioning is recognised in Daloz's (1986) work on mentorship, he suggests that a supportive tone to the relationship is so important because it lets the student move to her leading edge 'Under stress, we tend to slip back; we tighten our grip on what feels most secure. When we feel safe, on the other hand, we can relax and reach out' (Daloz 1986 p.219).

Support and Challenge: Related Literature

It seems appropriate and useful at this point to elaborate further on the work of Daloz (1986). In his text, 'Effective Teaching and Mentoring', he explores, and clearly describes, the characteristics of support and challenge and their influence on learning. He suggests that support refers to those acts through which the mentor affirms the validity of the student's present experience 'she lets him know through her empathy with his feelings or her comprehension of his words that he is understood .. in systems language she attempts to bring her boundaries into congruence with his' (p.212). In contrast, while the function of support is to bring boundaries together, challenge peels them apart. The mentor or teacher challenges through questioning tacit assumptions, introducing contradictory ideas or even refusing to answer questions. The function of challenge is seen as opening a gap between student and environment which creates tension in the student. This tension creates cognitive dissonance as described by Festinger (1957), a gap between one's perceptions and expectations which calls for closure and thus acts as a stimulus to learning. Festinger (1957) maintains there is an intrinsic human need to close such a dissonance, to harmonise it again with our own inner selves, suggesting that learning is about the move to close the gap.

In terms of student development, according to Daloz, when both support and challenge are low, little is likely to happen, there is stasis, things stay pretty much as they are. 'When support is enhanced, however, the potential for some sort of growth increases, but is likely to emerge from the inner needs of the learner rather from any stress imposed by the environment' (p.214). The learner will respond by feeling confirmed in his or her present state, but will not be stimulated to develop any further. Too much challenge in the absence of appropriate support can drive the insecure student into retreat. However, when both challenge and support are high, growth will occur and the learner will make progress.

The optimum condition for learning therefore, according to Daloz, would involve high degrees of challenge and support. In such a situation, he suggests, cognitive

growth is likely to be encouraged. This combination of high degrees of both support and challenge, though, may not always be found. In the context of teacher education, Cameron-Jones and O'Hara (1997) identified a high degree of support in the relationships between schoolteachers and their student teachers, and lesser degrees of challenge. They also recognised incongruity between the teachers' and the students' perception of support and challenge and report their findings to be in line with the general trend of the literature.

While the work of Daloz (1986), and Cameron Jones and O'Hara (1997) is carried out in different educational contexts, the findings are of value in understanding the process of learning in nurse education. It is indeed evident from the current study, and in particular from the preceding data presentation, that the principles of support and challenge are clearly influential in the experience of the student nurse during practice placements.

Conclusion

Analysis of the data identifies complex and dynamic perceptions of need. The student expectations from the preceptor are based on meeting these needs. Describing their experiences of preceptorship the students recognise 'personal and professional needs' which influence the process of learning from practice. The good preceptor recognises these needs and meets them through support and challenge. When the students feel supported this influences the ease with which they 'fit in' to the environment, they are more likely to ask questions, seek advice and ultimately learn from practice. When they feel valued as an individual and trusted to participate in care this influences self esteem which is necessary for the development of confidence and competence. As the students develop they recognise the need for challenge as a stimulus to learning. Challenge is recognised as pushing the boundaries, not only of what they can already do towards doing something new, but also of developing existing knowledge and skill to greater levels of complexity. The participants look primarily to the preceptor for providing such support and challenge.

Having explored the student perceptions of need, recognising in particular support and challenge, the implications for learning will now be described.

5.5 The Process of Learning

The overall aim of Preceptorship is to facilitate student learning. The student perceptions of learning and their experiences of the process will now be explored. While the environment and the supportive relationship have been extensively described in the previous section, the relationship to the process of learning will now be discussed. This theme shall be presented under the following headings which have evolved from the analysis: conditions for learning; influencing factors; learning strategies; outcomes and consequences.

Conditions

Three main conditions for learning are described by the students:

- the environment
- a supportive relationship
- a desire to learn

The Environment

Evidence described in the previous section identified the student perception of need to 'fit in' to the clinical environment and that feeling comfortable was a priority. The overall atmosphere in the environment can serve to either stimulate or intimidate the students and therefore directly affect their learning. The extent to which the students feel accepted, has a direct effect on their approach to learning. When accepted, they are less anxious and able to focus on asking questions and learning from practice. One student clearly recognises the influence of the environment in:

'I think what really sort of acts as a catalyst to your learning is when you go into a place and it's a friendly place, and they put you at your ease right away .. that is the atmosphere .. the general atmosphere that has a great bearing ..'
(10/16)

Another student supports this in:

'I learned more because I was relaxed and I was enjoying it .. and there was a bit of fun' (17/4)

These comments reflect the view of the majority of participants. However, reflecting on more negative experiences, the opposite effect on learning was succinctly expressed:

'it's really difficult to learn in an intimidating environment' (11/7)

This issue of the relationship between individual student learning and the environment was pursued further. When accepted within a comfortable yet stimulating environment the students were more likely to adopt a deep and more meaningful approach to learning, they felt more free to ask questions, verbalise their fears and anxieties, as well as seek support in learning. When they felt intimidated they were more likely to adopt a surface approach to learning by focusing on learning routines, getting on and getting the work done. This is evident in the following comparison one student makes between two placements:

'you're forced to learn .. you go home at night and you know for a fact that she would ask you .. well learn that for the next day .. you would go home and learn it .. but I didn't enjoy that whereas with the other one .. she didn't force you in any way to do it but she made it interesting, you wanted to know for yourself .. you wanted to go in the next day and say oh well I know a wee bit about that and is that right the preceptor she was just too overpowering and I couldn't remember a thing about ENT, and this other one was a medical ward and I've still, I know to this day .. I mean I can go to another medical ward and know, well that patient is getting that because .. and I learned that in that other ward, you know, but as for the stuff I learned in ENT, specifically for ENT I haven't a clue' (7/7)

This impact of the environment on student learning reinforces findings from previous research in nursing education (Fretwell 1982; Ogier 1982), and is consistent with the work of Entwistle and Ramsden (1983) in higher education. It is, however, evident that the participant's description of the environment is related to the social environment as opposed to the physical environment. That is, it is as much about the general 'atmosphere', the staff, the patients and the degree to which the student is

accepted and feels comfortable, as opposed to the specific type of learning environment, the experience available and the structure for learning. This finding supports that of Mackenzie (1992) who, in the context of community nursing, identifies: 'One of the first challenges is fitting into the learning environment - not so much a physical environment ... but a social environment of colleagues and patients and routines and accepted practices. It is as much to do with being accepted into the group, of which patients and professional carers play almost equal parts, as about learning what district nurses do' (p.685).

Supportive Relationship

The importance of a supportive relationship has already been established and its characteristics identified. 'Having someone there' is acknowledged as essential to the outcome of the placement as a learning experience as opposed to a work experience. From the analysis it is clear that 'having someone there' makes a difference by providing support in meeting learning outcomes as well as providing challenge to stimulate the process of learning.

Desire To learn

In exploring the conditions for learning, what the student brings to the situation directly influences the outcome. While it is acknowledged that environmental conditions are important the student's desire to learn is paramount. The students must play an active part in the process and accept responsibility for their own learning in any given situation. This is consistent with the literature pertaining to adult learning such as that of Knowles (1984/1993) and Brookfield (1986). The students within the study were aware of their own responsibility for learning, as evident in the following expression:

'.. you just have to go in with an open mind, you know and say well I want to learn, I'm willing to learn .. and you go and get on with it ..' (21/29)

Another student was more forceful and relates his responsibility to the length of placement:

'you are only there for a short length of time, you make the most of it .. four weeks isn't a great deal of time, it flies in so you've really sort of like ehm, knowledge wise and sort of like getting the most from your preceptor you've really got to go in with all guns blazing .. you know really go in and get the most that you can from them' (16/10)

In summary, analysis of the data establishes three main conditions for learning in practice as a comfortable, stimulating environment; a supportive relationship, and a desire to learn.

Influencing Factors

While these three conditions provide the optimum environment for learning, certain factors directly influenced the process of learning:

- Placement area
- Organisational issues
- Interpersonal issues

Placement Area:

One of the major factors influencing student learning was the placement area. While the significant features of the environment have already been identified and discussed, the specific placement areas, that is the type of area, and the influence on learning was highlighted. The participants frequently acknowledged and compared experiences in adult and mental health nursing environments as well as between hospital and community placements.

From the first interview, and reinforced throughout was the effect the student branch choice has on the experience. The participants reflected on the common foundation programme and acknowledged a clear difference in the quality of their learning experience in areas associated with branch choice, this was evident from participants undertaking both mental health and adult nursing courses. Quality of learning experience was often associated with level of involvement in direct care delivery as well as to the preceptor or staff perception of the student interest in the area.

In addition to level of interest in a specific branch of nursing, other factors appear to influence individual's attraction to areas within that branch. Client group, acute and continuing care, underpinning philosophy, hospital or community settings, may all attract different individuals and demand different learning styles and approaches to learning. For example, the overall environment in mental health tends to be more 'laid back' than an acute surgical unit and the formal 'hierarchical' structure in hospital settings is different from the more informal nature and approach in community settings. This was implicit in the following comments:

'branch choice .. it affects sort of you know how much you learn .. you know general student going to a mental health placement .. it wasn't .. I don't think the atmosphere there was conducive to my sort of learning ..' (16/16)

Not only the type of area but also the workload and organisation of care are influential. One participant commented on 'patient allocation' and 'primary nursing' structures as being more effective in learning about holistic care delivery in comparison to 'task allocation' which is still experienced in some areas. The busyness of the ward and the 'time' for teaching and learning influences not only the quality of learning and strategies adopted by the student but also the outcome, what is actually learned:

'I think the area includes the atmosphere in the ward ... I've been in wards where it's been, everything flashes by .. in the surgical ward and it's like hurley burley and it's .. there's no time for an atmosphere .. just non stop working and .. and even in those settings it's hard to learn things because preceptors .. they're involved in other things because it is a busy area .. sometimes I think it's too busy you can't learn, you know there's tasks and jobs that you could be doing at a slower pace, find the time to do it and you can't ... I think you learn time management more than anything else ..and prioritising care as well ...' (12/17)

It would appear from comments such as this that learning is more difficult to define in some situations. Rather than focusing on specific knowledge and skills more tacit learning is occurring in relation to organisational issues and care prioritising. Different areas are attractive to different individuals and this is summarised by one student who said:

'I think the kind of area you are working in has got a lot to do with it .. not just from the students point of view, if they're in an area they like or in an area they don't like .. I think the nursing staff are different in different areas I don't know, maybe it's not, maybe it's just me ... I always found the nurses in coronary care very serious, even with the patients .. and I know the patients are gravely ill .. but I don't know, I found them very serious and very official .. whereas in the surgical ward the patients and the staff are slightly more .. they're friendlier .. and maybe it's simply because you've got iller patients in coronary care .. I don't know but the staff just .. seem to be different in different areas .. maybe I'm just biased because I like surgical, I don't know' (14/35)

Analysis of the data suggests that the type of area whether general or specialist, acute or continuing care could influence the overall learning experience of the student. This may be related to personality, learning style or level of interest and support.

Organisational Issues.

Three main issues are raised under this heading:

- length of placement
- continuity of experience
- structured programme of learning experiences

Although these issues have been introduced earlier, their influence on learning will now be explored further.

Length of placement

The length of placement appears to have a direct effect on student learning. As already discussed the majority of placements were of a four week duration. Without exception the participants found this to be too short. By the time the student had 'settled down' and become familiar with the area and the staff, it was almost time to leave. Each of the participants identify a need for a settling in period before they could focus on learning. While the length of the placement was too short, returning to the same placement area for more senior experience was seen as very positive:

'when you go back to a ward you've no got this settling in type of period because you already know .. obviously in four weeks you canny know

everything .. but you know the basics .. but the next time you are there .. it's to work on different aspects which.. maybe you just touched on .. you're trying to strengthen other areas, you are trying to build on your basic skills and improve them .. for instance maybe it takes you a wee while to learn the admission process and the discharge protocols and things like that .. but when you've been there in part four maybe it will take you .. two weeks to get a good grasp and understanding .. but eh, if you are back in part six .. well .. you'll pick it up in three days so, it's different, and then you can concentrate on other aspects .. maybe like .. to liaison with other disciplines and to develop other skills .. learn more about medications and how to like .. contact doctors and things like that .. and you are doing things that are slightly at a higher level .. you're broadening your experience' (10/13)

Continuity

This quotation acknowledges the effect of length as well as continuity of placement on student learning. Within any placement the preceptor has the potential to provide continuity of experience. The impact this can have on learning and development is illustrated in:

'.. because your preceptor knows what you have done and what you are able to do and .. you know .. gives you a wee bit more guidance and then you can go on and do something else .. because she knows that you are capable of doing it .. whereas if you .. again if you are doing a dressing with somebody one day and a different person the next day, they don't know that you managed to do it the day before ..' (25/27)

The continuity provided by the preceptor is a major change from traditional nursing courses and central to the change in focus from a work experience to a learning experience. This was highlighted by a student who compared preceptorship to a previous experience in nurse education:

'in the old style of training .. you went to a ward and it was whatever staff nurse you got stuck with during the day and there was no continuity in the learning, you know .. you could be stuck with one staff nurse and that would be good because they would know what you had done the day before so they could get you to do something different the next day .. more was the case that you went in with one staff nurse, she would go on her days off and you went with someone else and done the exact same thing as you done the day before .. and there wasn't any intellectual challenge for you' (9/26)

Both continuity and length of placement have emerged as significant influences to the process of learning. Length of placement is important in allowing for the 'settling in' period. Without exception the participants acknowledged the anxiety of commencing a new placement area and the difficulty in focusing on learning during this period. In a four week placement the students were only just beginning to feel comfortable when it was time to leave and they perceived this as an influence on learning. Continuity of placement and of preceptor appears to have a more positive effect, allowing for 'building' of knowledge and skill as well as personal and professional development.

Clarity of expectations

Although continuity and length of experience are important another major factor in reducing anxiety and stimulating learning was clarification of expectations. Each of the participants expressed a need for clarification of expectations on arrival at any new clinical placement. The following comment reflects the opinion of many:

'.. if you sit down initially and you discuss what's expected from you and what you expect from the placement .. that can all be sorted out before you walk out the door and go into the ward to start, you know, then they know what you can do and you know what they want you to do ..' (6/34)

Structure

As well as clarifying expectations at the outset, participants expressed the need for structure in the form of a planned programme. The link between having a programme and role clarity has previously been identified. However it also appears that a structured programme has the potential to influence the quality of learning in a placement:

'If most preceptors or all preceptors had a programme of learning for their ward then you would get much more out of it .. if you sort of, you know go in there blind .. it's good to know what's going to happen within that four weeks .. It would give you some structure and also it would introduce you to experiences that you've not ..ehm .. it would introduce you to knowledge that you wouldn't have gained in college' (16/11)

Another student described the way in which this could influence learning:

'it was helpful (having a plan) because you knew what you were going to be doing and you could go and read up on it .. like have a wee bit prior knowledge to stuff that you were going to do that .. you were no sure about .. and it gave you a structure to what basically you were going to do for the month .. what you do .. how far you are going to progress and if there was anything that wasnae in there that you were wanting to do (you could say) it's a benefit .. when you go to some wards and they've no got one, well you are maybe no going to do half the stuff naso gastric tubes and that, well obviously you can only do it when they come up, but if they've got the structure down well you know that that's what they've got down and you'll get to do it .. if they've no got a structure .. well they forget' (23/11)

A planned programme was often the vehicle for discussion in which student needs were identified. Individual's skill deficit could be discussed and access to experience arranged. Experience specifically available to the clinical area could be highlighted and access facilitated. The antithesis to this was expressed in:

'(when there is no structure or support) .. It's a frustrating feeling .. sometimes you are out and you are learning nothing .. you feel as if you are just left .. like the general dogsbody to do all the .. to go round and do all the blood pressures, do all the temperatures and all the different things .. whereas I feel that .. do you know what I mean?.. you don't mind .. I mean obviously you do that .. you don't mind doing that .. but as long as you are learning maybe even something ..' (18/8)

It is evident from the analysis that structure, in the form of a planned programme, influences the student learning experience. A programme or plan is often used as an instrument for communicating and clarifying expectations, making explicit experience available to meet predetermined learning outcomes and skills acquisition and thus reducing anxiety. The extent to which this is realised is, however, dependent upon the level of communication between preceptor and student.

Interpersonal Issues

The process of learning from practice is without doubt influenced by the interpersonal relationships formed between the student and the personnel in the practice areas. The preceptor/student relationship has already been addressed, it is

now important to explore the specific influence this relationship has on the student's learning. The influence of an individual preceptor is evident in the following comment:

'because she was the type of person you'll learn a lot from, and she took you through everything step by step .. you know and you learned a great deal from her, and she was the type of person as well .. give you a wee bit of responsibility and you felt good about it, you know .. you felt quite chuffed with yourself if you were doing something on your own and she was the type of person who would praise you a lot as well ahm and not in ... if you had done something wrong or you hadn't done something quite right, then she would sit down and wouldn't bawl you out, but she would sit down and explain .. well you could have done it this way or that way, you know that type of person' (5/7)

The above comment captures the impact of the individual preceptor's personality and the skill involved in facilitating student learning. Interpersonal and communication skills are central to developing an effective teaching and learning relationship. An effective relationship facilitates feedback being given and received as a constructive process. Without exception the participants express the influence of good communication on the achievement of learning outcomes:

'... I definitely think it helps your learning because, I think you tend to go and ask them more and tend to go to them for more support and advice .. whereas if you don't get on with them I think you tend to say ... no I'm not going to ask, she's not approachable ...' (1/27)

When the student 'gets on' with the preceptor they are more likely to ask questions, voice fears and anxieties and be receptive to advice and criticism. The extent to which the student respects the preceptor appears to influence this:

'.. part of the learning process is ehm, being able to talk about the mistakes that you have made, learning from them .. and if you, again if you don't have any respect for that person that's your preceptor you can't do that' (9/9)

The issue of respect for the preceptor was reinforced by other participants in comments such as:

'looking back .. the placements where I've respected my preceptors I've done really well and got a lot out of the placement I would emphasise again, I think for me the most important point is that .. eh .. the second isn't even a close second .. is that I strike up a good relationship with them as a person .. you know what I mean? .. I feel as though if you have a good relationship with your preceptor it does have a sort of positive knock on effect .. you are more likely to enjoy your time there therefore .. if you enjoy doing a job .. you'll get more out of doing it and I think that's pretty much read' (22/27)

The impact of the relationship between preceptor and student on the process of learning is evident throughout the study. If the preceptor is approachable the student is more inclined to seek advice. On the other hand if the preceptor is unapproachable the student is less likely to seek help when needed or may not ask a question essential for the development of knowledge and understanding. At best this may impact negatively on the development of confidence and competence and at worse, result in unsafe practice. The importance of good communication has been made explicit in establishing and building such a relationship. Good communication has also been implicit in the participants' description of the process of learning and the strategies used by both students and preceptors in facilitating learning from practice. These strategies will now be identified and explored.

Learning Strategies

In response to questions regarding the experience of preceptorship the participants freely describe specific strategies which they have adopted to maximise learning.

As the preceptor is seen as someone who is responsible for facilitating learning, it is important for the student to identify with the preceptor and establish a relationship. The student often utilises 'teacher pleasing strategies' in order to be accepted by the preceptor and maximise the potential for learning within the relationship. Similar findings were highlighted by Mackenzie (1992) in an ethnographic study of student district nurse experiences. Mackenzie found that every student made reference to strategies used to gain acceptance and to maintain their place in the group (p. 695).

Much of the literature pertaining to preceptorship and to learning in clinical practice focuses on the concept of 'modelling'. Bandura's 'social learning theory' is often used to explain the process of learning in social situations. The significance of role modelling is reinforced within this current study, however critical analysis of the data demonstrates active learning strategies which are not explained within the social learning framework. It has become clear that different strategies are adopted depending on the type of care-giving. The most obvious distinction is made between learning to participate in 'physical' care giving and 'psychological' care-giving. The strategies emerging from the data will now be described before exploring and identifying theoretical links.

Getting Involved

In response to a direct question regarding learning from practice, the participants, without exception identified getting involved and 'being allowed to do' as the most important influence on their learning. While all agreed that observation, particularly through listening and watching are constantly used strategies, 'the need to do' was paramount. This was clear from the first participant who expressed:

'I mean the important thing is getting in and actually doing it because it's like riding a car, you can read it in a book but then to get into a car it's just totally different, but in saying that, I mean the preceptors .. they've got to be there I think because they obviously know whether you're at a level as well to go in there and do it ... I think there's got to be someone there to say, look .. you've done that right or you've done that wrong ... and they either show you how to do it .. but I think as well, to be able to see a person doing it first .. because I couldn't just go in and do an admission without having seen somebody else doing it first ... it's like a bridge I think a lot of the time, your preceptor .. they are there to bridge that gap from doing your theory to doing, actually carrying it out' (1/24)

Each of the participants acknowledged the need to observe practice but also to become active participants as soon as possible. The most positive learning experiences were those where the preceptor involved the student from the beginning, demonstrating what they were doing before allowing the student to carry out the care

under their supervision. The need for supervision was acknowledged as essential to the development of confidence as well as to ensuring safe practice.

The most powerful influence on learning in practice is participation in care delivery and 'getting to do'. Once the student has been shown, although apprehensive, they desire to get to do things on their own, to try out and ensure they are able. This finding is consistent with that of Mackenzie (1992) who asserted that learning by doing is crucial to the students who talk of 'itching' to be involved and learning more by themselves.

Skill Development

The need for demonstration and practice in the clinical environment is essential to the building of knowledge and skill. While the majority of essential skills are introduced in the college setting, it is the reality of the clinical context which adds complexity to the most simple procedure. This is acknowledged throughout and reflected in the comment referred to earlier:

'.. say like aseptic technique, you would have been taught it in college but it's completely different when you are out there' (4/17)

Following further probing, this student goes on to discuss the way in which the preceptor 'talks through' the procedure and highlights the significant features of the activity.

'Talking Through'

Each of the participants acknowledge the significance of 'being talked through' a situation and identify the influence this has on the learning outcome and upon their perceptions of the learning experience. Another student explains this:

'the preceptor .. whenever they are doing something they will take you and .. eh, talk you through it .. and then .. the next time they'll say right you can do that the next time, and again talk you through it .. that's the sort of experience that I've had .. catheterisation .. the same, they'll do it .. they'll say come and watch, the next time you'll do it and I'll talk you through it and

then .. and then you feel confident enough to do it with somebody else..'

(25/7)

In learning practical skills it is important for the student to observe then participate in practice. The presence of the preceptor allows the student to 'try out' the behaviour with ongoing verbal and non verbal feedback. This allows the student to alter their actions in relation to the individual patient and context, highlighting subtle behaviours, movements or actions which cannot be prescribed but are essential to skill development. Following supervised practice the participants acknowledge the need to carry out the procedures on their own. It is only through exposure to practice and experience 'of doing' that the student develops in competence and confidence.

The significance of participation in development of knowledge and skill is evident, however participation alone is not sufficient for developing understanding. Communication in the form of discussion, explanation and feedback, enhanced the process of learning from practice. When feedback is immediate, its potential for modifying learning is improved.

Feedback

The influence of feedback on learning is well established throughout previous nursing and education literature and supported within the current study as a significant influence on the process of learning. It would appear that having a 'good' preceptor can positively influence the nature and quality of feedback. This is evident in the following encounter:

'that's the other thing about preceptorship .. the feedback .. it's really important. I always ask them to give me feedback, whether it's good or bad ..

I. And has that happened? ..

yes all the time .. they tell you what you are doing right and what you can improve upon. I have found it very useful, you need that, how else are you going to know how you are doing, or if what you are doing is right. It's the way they tell you that is important .. not to tell you or bring you down in front of a patient or others ... I've always found feedback very constructive and

the preceptors that are interested in you are very good at giving you feedback'
(24/4)

The potential for giving and receiving feedback is maximised in a positive preceptorship experience. The close working relationship between student and preceptor allows for immediate and ongoing feedback. Responsibility inherent within the preceptor role may also influence the process. When there is no identified support person for students in clinical practice, feedback is more likely to be fragmented, as responsibility is dispersed throughout all registered nurses.

Each of the participants discussed the impact of feedback and often linked this to the preceptor role. In the early course parts the student depends primarily on the preceptor for feedback. However, as they progressed they become more receptive to feedback from other members of the team. One student describes this in:

'I think in part six you are looking for it (feedback) from everybody because .. you're not so much with your preceptor and you are working with different people .. I think at the end you need to take it from everybody .. I think at the beginning it's better to be just your preceptor .. that says no, you're not doing this right .. cause you would end up feeling .. oh everybody's on my back, I'm making a pure mess of this'
(13/25)

This change in the students' perception of feedback may be linked to their changing role and level of integration within the team as well as to an increase in self awareness. The preceptor plays such a pivotal role in the early stages allowing for constructive feedback to be given within a supportive relationship. The student looks to the preceptor for feedback and that given by others may be interpreted as destructive depending on the context. This is a major shift from traditional nursing students who, in the absence of a named preceptor, would depend on feedback from a variety of sources.

The quality and timing of feedback was influenced by the amount of time the preceptor and student worked together. As identified earlier, however, this often depended upon the shift patterns. Each of the participants acknowledged the impact of working with a 'good preceptor'. The opportunity to work with this individual

clearly influenced the process of learning. When working with the preceptor feedback was more immediate and spontaneous. This allowed the student to alter her practice, discuss understanding of the specific situation and make connections with prior knowledge and experience.

Community Practice

When acknowledging the impact of access to the preceptor the majority of participants discussed the difference between community and hospital placements. While on community placements the student is more likely to be with the preceptor on a one to one ratio, participating in care delivery. In hospital placements this ratio is more dilute with the preceptor often involved in other responsibilities with less time to spend with the student. The access to the preceptor therefore influences not only the relationship established but also the quality and continuity of feedback:

'preceptorship works best out in the community because you are always with your preceptor ... you are constantly with your preceptor all the time and I feel you learn .. you can ask questions like .. just .. you know how if you are doing something on the spur of the moment you can ask a question and your preceptor is there to answer it .. I've learned a lot more out in the community than I have in the wards .. being with the preceptor at all times .. and you are getting a lot of experience doing things .. because sometimes when you are in the wards you are just a pair of hands ..' (18/2)

As well as providing opportunity to ask questions, being with the preceptor and working with the preceptor allows for those learning opportunities which present themselves serendipitously. In Brookfield's (1986) terms this allows the preceptor to use the 'teachable moment' addressing issues and situations as they arise. That teachable moment during the community placement is often in transit, going from one home to another. This is acknowledged by the students in comments such as:

'in the community you do have that wee bit more time as you're going from different places where you are visiting .. they would talk things over with you ...' (8/24)

It would appear that the very nature of community practice and the time spent travelling between clients allows for reflection and discussion prior to, and on completion of, the visit. This in itself is identified as a teaching and learning situation, strategically used as such by the 'good preceptor' and valued by the student.

In the final six months of the course the students returned to community practice and were given more responsibility for care delivery. At this stage they were more fully involved as part of the nursing team and would often carry out visits on their own at the discretion of the registered nurse. Reflecting on this experience the participants highlight the development of confidence through such responsibility but also the appreciation of collaboration as a learning strategy. Discussing community experience one student explains:

'it's good because it gives you the real world so to speak .. you've got your own (patients) .. you've got to make your own decisions on dressings or whatever .. obviously you still go back and discuss it with .. but even the staff nurses come back and discuss it .. do you think I've put the right dressing on? Or what do you think? .. ehm .. it's a lot better ... you see it from other people's perspectives as well as your own' (19/8)

This increased responsibility and opportunity to carry out care without direct supervision was recognised and valued by each of the participants. However, also significant to learning, was the process of collaboration and discussion with the nursing team which encouraged reflection and provided support and reassurance.

Preceptor Influence on Learning

While the students clearly identify their individual responsibility for learning from practice and the strategies they use to do so, they also acknowledge the strategies used by the preceptor which influence learning. For example the participants differentiate between observing as watching and listening in an ongoing way in a passive sense, to being shown by the preceptor and watching in a more active sense. This is linked to the level of attention given to any one activity and as such the

quality of outcome. One student describes how the preceptor stimulates attention, and the influence this has on observation:

'right I'll be doing this assessment today but come Wednesday .. I want you to do it .. and you sort of say to yourself .. well I'm going to listen to what you are going to do at this time, you know .. it gives the student the incentive to say well, I'd better listen just now because I might be doing the next one'

(8/25)

While observation is accepted and expressed as a fundamental strategy for learning, the above comment reinforces the potential influence of the preceptor on the process. The following experiences of community practice were narrated by students to illustrate preceptor strategies which were challenging and which stimulated learning:

'we used to go into the houses .. before we went in he would say, I'm not going to tell you anything about them. I want you to make your own observations and see what you come up with that was good it made me think .. at that particular time and not just being an observer .. then you come out and give him the run down and he would say whether you're on the right lines ... so it was good in that way .. if you got it right it made you feel so good .. I don't always get it right ... but that was good I enjoyed that type of learning ..'

(5/11)

Similar comments were made by another student reinforcing the value of such preceptor teaching strategies:

'they would talk things over with you .. just...simple things like at the start he would explain things to you and then as you were going along he would say .. well, what did you notice in there? what did you think? how do you feel that client has adapted to this? or what do you think his symptoms are? or even just simple things like, What do you think his illness is? . . .'

(8/24)

Whilst this strategy of questioning is used in many clinical learning situations, travelling in the community provides a captive environment for interaction, discussion and reflection between the preceptor and student. In a ward situation it is more likely the preceptor and the student would work together intermittently, each getting involved in separate tasks after a collaborative event.

Questioning

'Asking questions' is identified by the students as the most frequent strategy they use to learn from practice. They also recognise the influence of 'being questioned' by the preceptor. This was identified as a strategy which heightened attention. Responding to questions made the students think and stimulated learning. The following comments recognise how the preceptors challenge through questioning:

'(questioning) . . . I think it's good you know 'cause it's maybe something you haven't thought about, I mean maybe .. going along and thinking you know something but you don't really know it .. so .. even if you know they are going to ask you questions it makes you read .. it makes me read when I know they're going to ask me questions about certain things . . . ' (4/31)

Manley (1997) advises that asking questions is perhaps one of the easiest and most effective methods of teaching and precepting. The process of questioning as a teaching strategy is well recognised throughout the literature. The advantage of this strategy is twofold. When the preceptor questions the student's basic assumptions and premises, plays the devil's advocate and probes weak areas, this not only lets the student know that he is right or wrong on this occasion, but also teaches the sort of self questioning, diagnosing and correction strategies that is required for reflection and lifelong learning in nursing.

Such preceptor strategies as questioning and alerting to experience heighten the student's attention. Each clinical setting is different and presents the student with a profusion of complex stimuli. What each student observes is influenced by many factors not least previous experience. The preceptor influences observation, not only by stimulating the student's attention, but also by guiding the focus to significant elements or behaviours.

Role Modelling

Participants often described the preceptor as a role model and many examples of role modelling were discussed. One student uses the analogy of a sponge to illustrate the process of learning through modelling:

I. In what way did you learn from your preceptor?

St. In all ways .. like a sponge .. you just soaked everything that they were doing, you watched them, you listened to them, you followed them .. just everything that they were doing. People all do things differently so you watched how they did things and you would say to yourself, I liked how she did that, I'll try to do that .. that was good. There were others you would watch and you would think, I wouldn't do that that way .. you took bits from everybody .. what you liked about them you tried to take on board. The good ones you would always be asking questions, if they were interested in you and your learning it was easy to ask .. you didn't worry, oh will that sound stupid, or should I know that .. but there were others whom you just wouldn't ask, but you still learned .. you learned about bad practice and you know the things that you wouldn't do yourself (24/2)

Another participant described the strategic activity of learning through modelling:

'I've definitely learned .. Just being a role model, that's what it is .. And it's good because we go to different places, it gives us a chance to compare .. I mean I see one staff nurse reacting in a situation in a ward and reacting in a different way in another ward .. and I kind of take out the bits that I like from both of them .. the bits that I like, you know what I mean?' (22/15)

While this student acknowledges the importance of role modelling he goes on to describe his own individual strategy for learning.

Communication Skills

The preceding discussion highlights the effect of role modelling on learning from practice. However, further analysis demonstrates a specific influence of modelling on affective behaviours, in particular communication skills and attitudes. Many participants express concern related to learning communication skills and go on to discuss the importance of watching and listening to how the preceptor, and other staff, communicate with patients, relatives and others within the multidisciplinary team. This is described in the following student experience:

'one of the surgical wards I've been in .. where they've been told the diagnosis, where the prognosis is very poor .. it's the way the nurse attended to their .. like psychological needs .. and I'll try to remember and do that if ever I'm in that position again .. not really the physical care they're giving but it's the psychological .. you always notice ... I think even observing how they communicate with patients .. you can always say well they approach the

patient about that in that way .. so I'll do that in future ... or even watching other nurses and how they approach the patient, 'cause they are all different, all have different ways of approaching .. and really just like assess .. seeing how you find where .. you feel most comfortable .. I think really it's just communication skills which influence me more .. I think just seeing the way they (the preceptors) communicate with patients, the way they approach patients .. just something you always remember' (2/27)

This focus on communication skill is reinforced in other comments such as:

'you listen, even if it's .. at the station .. listen how they talk to people, how they communicate .. with relatives in a situation like that .. just like take that on board' (16/9)

The extent to which the student adopts these behaviours is described in:

'practising as well .. because I've been in to a terminal case once .. I went back into the house after the person had died to pick up stuff .. and it was again trying to be empathetic and sympathetic and just ehm .. just copying what and approaching .. and talking to them in the same way that the district nurse did .. the preceptor .. skills like that .. that's important skill' (12/24)

The influence of observation and modelling as strategies for learning how to communicate with patients and relatives is clearly evident. This is of particular significance in 'emotional' situations where the student is inexperienced and anxious to meet individual patient or family needs.

Tacit Learning

While a number of strategies have been identified much of what the students describe in relation to their experience highlights the tacit nature of learning in practice. When working with the preceptors and staff the students are constantly watching and listening to interactions with patients and other team members. The influence this has is described in:

'just listening to them talking to patients, you pick up on that .. you learn from that and then you feel a bit more confident about talking to patients yourself .. I've learned loads ... sometimes you don't think you have picked anything up at all .. it's not until you are questioned .. a lot of the time that's what's good about it you don't feel as if you are being taught constantly .. but you are .. you don't feel that you are' (25/2)

Another important feature of tacit learning is evident in 'stories'. One student clearly recognises the value of the stories told by staff:

'she'll tell you about her experiences, she'll tell you about a particular patient .. the kind of things you want to know at this stage .. and she'll tell you a story of how she dealt with that .. how difficult it was and what options .. you know .. sometimes she'll tell it in a very humorous way .. you know a disaster ... but as I say the kind of things you want to know' (17/10)

The tacit, as well as active nature of learning from working with practitioners is explored further and explained on page 214.

Outcomes and Consequences

Having looked at the conditions, influencing factors and strategies in the process of learning it is now appropriate to describe the outcomes in relation to the influence of preceptorship on student learning. Accepting the earlier description of the student perceptions of good and bad preceptors, the analysis of outcome is described on the basis of the student experience of a positive preceptorship, identifying the potential for maximising learning.

It is evident from the analysis that the aim of preceptorship, to facilitate student learning, is realised when a positive preceptor student relationship is established. The main advantage is that there is a named person responsible for clarifying learning outcomes and assisting the student in the achievement of these outcomes. When the preceptor had a planned programme for the student, this provided structure, clarified expectations and identified experience available to meet outcomes. This impacted on the quality of the experience and the student learning.

The preceptor provided continuity in terms of the student experience. This continuity allowed for ongoing assessment, knowledge building and skill development. The preceptor guided the student through the simple to the more

complex skills and procedures depending on his or her individual developmental needs.

Learning was achieved through observation, supervised practice and guided participation in care delivery. The most important factor influencing the quality of learning was the communication between the preceptor and student. This was significant in terms of guiding through practical skill development using both verbal and non verbal cues. The close working relationship in preceptorship facilitated discussion, reflection, and eventually collaboration in care giving as the student progressed. This allowed for sharing of ideas, assessment and clarification of understanding.

Working with the preceptor allowed for ongoing feedback on performance. Feedback influenced student learning and provided reassurance in relation to safe practice. Constructive feedback provided a catalyst for learning by increasing confidence, which affected self esteem and ultimately impacted upon performance. Improved performance in turn had a positive effect on motivation thus providing stimulus for new learning and further development of confidence.

Summary

Observation of the data highlights a complex array of strategies used in learning from practice. In the early course stages the participants appear to be more dependent upon supervised practice, however as they develop in confidence and competence they appear to be more focused on discussion, collaboration and reflection as strategies for learning.

Evidence of role modelling is illustrated throughout the study, particularly in relation to learning communication and affective skills. Strategies involving verbal and non verbal interactions were consistently emphasised and utilised in learning psychomotor skills and physical care giving. Tacit learning and the importance of narrative, listening to the stories of patients and staff, are recognised as a means of

developing understanding of a given situation or response. Good communication is essential to the overall process of learning and central to discussion, explanation and collaborative reflection on practice.

Through the formal one to one relationship the preceptor has the potential to influence the quality of student learning. The preceptor acts as a vehicle for ensuring access to relevant and appropriate experiences, providing structure to the placement and assisting in the achievement of outcomes. The student learns through the process of guided participation and reflection on practice as well as role modelling. A fitting summary of the value of this relationship is provided in the following quotation from a student:

'I definitely think having a preceptor is a big help, if of course the preceptor is good .. I definitely think it's wonderful .. some wards you go into and you have a preceptor who is wonderful and it makes all the difference .. and I think to your learning as well, I think you learn an awful lot more as well, you want to learn more, having one . . . ' (7/25)

5.6 Process of Development

The experience of preceptorship influences not only student learning but also development. Each of the participants discussed their personal and professional development as well as changing perceptions throughout the course. This theme shall now be analysed to illuminate the student perceptions of the developmental process and the changes which have occurred in relation to their experience of preceptorship and learning within the clinical area. The analysis will focus on the following perceptions emerging from the data:

- Changing Needs
- Changing Role
- Preparation for Registration
- Influencing Factors

Changing Needs

Student perceptions of needs have been discussed earlier, differentiating between social and learning needs. It is clear from the analysis that student needs in relation to preceptorship change as they develop through the course. In the early course parts the student depends on the preceptor to provide support, guidance and structure to the placement. The need to 'have someone there' is paramount. The participants clearly describe their lack of knowledge and confidence in the early course stages and the concomitant need to get involved - 'to do' - in order to gain confidence.

As the students progress from one course part (semester) to another their level of dependence on the preceptor lessens. While a degree of guidance and supervision is required throughout, the focus tends to move from the simple to the more complex behaviours in which the student becomes involved. In the early course stages the focus is on gaining experience and confidence in the essential skills of nursing such as caring for patient's hygiene needs, talking to patients and developing psychomotor skills for example measuring blood pressure and giving injections. They look to the

preceptors to facilitate such experience and depend on them for guidance, supervision and feedback, which subsequently impacts on development. This is recognised in comments such as:

'It's confidence building 'cause at the end of the day I can say, I've done that, I've been able to .. give an injection .. it's a simple thing like that .. I've been supervised doing it and there was no problem ... confidence in looking back and saying, I've done that before, I can get on and do it again' (2/25)

The preceptors' role in demonstrating and supervising is highly valued by the students who talk about 'shadowing' them in order to access as much experience as possible. As they develop in confidence the need to do things on their own, to test their own ability is essential, as another student said:

'at this stage I feel it's important to do things on your own because obviously you are going to have to do them yourself when you qualify .. it does increase your confidence .. being able to do something and know that when you go to your next placement .. well that's something I've learned .. I can take that with me' (18/23)

The impact this has on learning is expressed by another student who said:

'it's very important because that's the only way that you are going to learn and get the confidence .. you've got to do it on your own' (20/10)

Doing something for the first time and in particular doing without direct supervision is an anxiety provoking experience for the student and a major step in the development of confidence and skill. One mental health branch student describes this quite clearly in the following account:

'a lot of the things I've done in the past few months I've always been a bit nervous about doing for the first time, but I've always known that once I do it that'll be me .. it's then on my own .. I know I've done that and I won't be nervous about it again and it's just things like .. I mean they might not sound like anything to yourself .. I was always nervous about reading out a relaxation script .. because I was worried that they might not relax when I done it .. I've done that a good few times now and I've had positive feedback and I was worried about going to someone's house for the first time myself and I've done that .. and I was worried about sitting with a patient in an

*interview room once myself and then I've done that loads of times now ... I do
I feel more self confident now ...'* (22/16)

The significance of carrying out a procedure or being directly involved in an activity for the first time was acknowledged by the majority of students. Many discussed feelings of anxiety in such situations. This was, however, recognised as an important step in the development process. The importance of feedback from the preceptor was acknowledged as a means of ensuring safe practice and developing confidence 'in doing' and knowing that what is done is 'right'.

Every student made reference to the development of confidence as a positive influence on performance. The effect of the preceptor on student confidence was recognised in a recent American study by Goldenberg et al (1997), who concluded that preceptorship has value in raising student's confidence levels in performing nurses work (p. 309).

In the present study, as the students gain experience, their focus moves from what they perceive as the basic skills to the more complex skills. This is consistent with the work of MacLeod (1996) who explains how confidence changes understanding when she states:

over time, the understanding of similar experiences changes. What was major becomes minor; what was challenging and uncommon becomes commonplace and routine (p.56)

Through experience the students in the current study describe how they build a repertoire of skills with which they become comfortable. Their aim is to build on this repertoire with new and more challenging experiences, which they often perceive as the more technical and managerial aspects of care. In order to build upon this repertoire, a degree of structure is required in the early course parts but as the student develops there is less dependence on structure.

As the students developed and proceeded through the course their level of self awareness increased. In the final placements they were more aware of their own learning needs, recognising strengths and weaknesses and actively seeking specific experience to address any skill deficit. One student describes this in the following quotation:

'over the last year I've said this is what I need to know, what I need to do, what I need experience in ... you are more confident in the things that you know but you are (also) more confident in saying .. listen .. if you don't know something you just need to say it because there is no point in going out and trying to do something if you've not done it before' (18/11)

Another student elaborated on this theme when she said:

'there is specific things you want to learn .. you don't want to cover old ground all the time .. you say, I want to learn this .. you become more aware of your limitations, your weakness and your strengths .. it's looking at yourself more and saying, well what do I need to learn, what am I good at, what am I bad at ..' (5/25)

Although some students were clearly aware of their own learning needs from early on, they often didn't have the confidence to seek help, another student describes how this changes in:

'I would now (seek help) then I wouldn't have because it was quite near the beginning of the course and I didn't have the confidence to do it then, I didn't feel confident either in myself or in the system really' (6/8)

This student recognises the development of confidence in herself as well as her knowledge of the health care system which has developed through experience. Recognising limitations but having confidence to acknowledge and seek help is also identified as a feature of new staff nurse behaviour in a study by Macleod Clark and Maben (1996). These authors recognise the paradox when students express a lack of confidence but demonstrate confidence in saying when they feel unprepared.

From 'Shadowing' to 'Letting Go'

The term 'shadowing' was frequently used by the students to describe the strategy of following the preceptor, observing their practice and seeking experience from them. Shadowing was more evident in the early course parts, however, as the students developed in confidence they began to 'let go' and gradually assume more responsibility for different skills and practices. This is explained by a student who said:

'you don't rely on them so much .. you are trying to get that bit more confidence in part six of doing .. even like the basic stuff that you would have gone back to your preceptor and asked .. I think you grow in confidence so you don't rely on them as much .. you still rely on them ... you are still going back ... double check this .. and you get more confident .. they'll check it and say aye fine .. but you know you are right ...' (23/27)

In the final placements the students became more fully involved in the 'team', assuming increasing responsibility and autonomy and 'letting go' of the dependence on the preceptor. The preceptors facilitated this process by encouraging the student to do things without direct supervision and reassuring them of their support as described in the following statement:

'I'm getting to do all the work they do .. I'm expected to do it .. they said if you have any problems come back, but on you go .. you should be able to do that now .. we've seen you and we know you can do it so .. I went on and done it .. it's good that sort of thing .. that's like giving you reassurance and saying if you have any problems come back but also giving you a wee bit of respect and credit by saying, we know you can do it' (22/9)

In such situations the preceptor was described as a 'safety net', there should they be needed. The students emphasised the need to do things on their own, to test their own ability and skill. However, the knowledge that the preceptor was there as a 'safety net' was essential. This is reflective of the changing role of both student and preceptor which shall now be explored further.

Changing Role

Analysis of the data clearly demonstrates the dynamic nature of preceptorship evident in the changing roles as students progress through the course. This is recognised by participants and discussed in relation to expectations, perceptions and level of involvement. As the students developed they experienced a change in expectations from the preceptors, this was expressed by many in comments such as, *'they expect more from you now'* (in the final semester) with some students suggesting they expect too much. However, not only did the preceptors' expectations change but also the student expectations of themselves. Many used the phrase *'I should be able to do that now'* or *'I shouldn't need the same supervision now'*. This recognition of their own development is reflected in the following observation:

'I think they expect more of you but I think it's only right that they should expect more of you, I mean you are part five, you shouldn't be going in there and sitting about like a part two' (15/35)

One student described the realisation of his changing role when he compared an experience of returning to an area as a senior student and the impact this had:

'I remember I'd done two placements in thoracic, one in part three and it was good, I got a lot of support and I got to spend time with the patients .. I went back in part six and they were expecting a lot more of me and they made that perfectly clear ... I was doing a lot more of the paperwork, admissions, clerical work, taking phone calls, arranging X rays etc. .. everything that the rest of the staff were doing and I realised that I wasn't getting as much time to spend with the patients as I had previously had in part three ... I thought cause I had enjoyed the placement so much in part three and I got so much support from all the staff and preceptor ... I went back in part six and I don't know whether it was I'd seen it through rose coloured spectacles when I was there the first time and seeing how it was when I went back .. it was a bit of .. oh this isn't how I remember this to be .. maybe it was because they were expecting a lot more of me and they were pushing me to do other things .. and because I enjoyed the contact with the patients and being able to sit down and spend time with them .. but when I was doing that .. you had another four or five other things to do in the back of your mind and it was difficult to concentrate on both and get involved with them' (3/8)

This explanation not only reflects changing expectations but also the changing perception of the nurse's role. In the early course stages the student tends to perceive the nurse's role in terms of direct patient care. The administrative aspects of the role may not be recognised and are certainly not the priority for learning. This was discussed by many participants who only began to recognise 'paperwork' as an integral component of the role in the latter course stages. Another student said:

'.. at the beginning I wasn't interested in all that paperwork that goes on, I wanted to learn what was .. you know what was going on in the ward, I knew the paperwork would come .. I'm getting more paperwork now which I didn't bother about at the start .. now I realise that it's important and at this stage you know I'm quite happy to be doing it .. although I still want to be out doing something ...' (15/27)

These comments reflect student development and the changing focus of learning. It is only as the students gain experience that they can extend their perceptions of nursing practice and begin to see 'the bigger picture'.

Integration into the Team

A major element of the changing role lies in the degree to which the student feels like a member of the team. As they progress on the course their role within the team is continuously extended. In the early course stages they see themselves as a peripheral part of the team, involved to some extent, whereas in the later course stages they are expected to participate more fully as an integral team member. Many students recognise this change and identify its impact on development as described in:

'they see you as part of that nursing team .. which is good .. again it's confidence building .. it's much more freeing as well you're kinda more autonomous .. I'm more free to sort of like prioritise things .. prioritise my care for my patients .. and organise things for my own patients .. I've found my role has changed since parts two and three ... I'm much more thoughtful ... I think they (the staff) don't see me as being sort of like a student .. they do .. they know you are a student but they don't see you like that .. they see you sort of like a member of that team .. a member of that nursing team ...' (16/6)

This student went on to describe the realisation of his role change when working with more junior students:

'.. another instance in like part five .. there was a part three and part one students out .. our role was like completely different from what theirs was .. and I found out I was much more .. that's when it really struck me that my role had changed ... in comparison to them your role is completely different .. they are still .. sort of guidance .. but you are more free to provide and organise the care .. there was less involvement from the preceptor .. they were still there you know, but it was .. again it was sort of like minimum'

(16/6)

As the students developed and their role changed, many described how they became more 'thoughtful'. Integration into the team influenced the quality of thinking, the students become more aware of their responsibility and more critical in their thinking. The following quotation identifies the response to increased responsibility:

'before you had it all done for you, you just went and done it and you never really thought whereas now .. I've got my case load .. it makes you think a lot more'

(19/7)

Rostered Service

The final six months of the course is recognised as the 'rostered service' component. At this stage the expectation is that the student will participate as a full member of the nursing team, role change is evident and the impact this has is demonstrated in the following comment:

'.. I mean at the beginning of your training you're not counted in the numbers .. you're not needed .. you know you are there to learn and that's it, whereas whenever you get to this stage you're part of the team, you're counted in the numbers and you are more important because they look at you as a team member not just a student there for the sake of it'

(21/25)

This student highlights the positive influence on self worth when she was accepted as a team member. She goes on to explain this in relation to 'being listened to' as described in the comment:

'you get listened to more now than you did at the beginning, because at the beginning you knew nothing .. you know that was it you knew nothing .. and now the minute you say, oh I'm a part five or a part six student they say, oh right, that's fine .. and listen to whatever you've got to say .. you feel really

important, you know you feel part of the team It builds your confidence because you're getting listened to .. you don't feel so insignificant' (21/25)

This notion of being listened to was emphasised frequently and appeared to be interpreted by the students as a form of feedback reflecting the degree of progress and growing reciprocity within the relationship with preceptor and other team members. The relationship is described as being more equal at this stage as another student said:

'at the start you were desperate for somebody but .. now you are more equal .. not equal, there is always that wee bit of .. you're the staff nurse .. I'm the preceptor, you're the student .. but it's more ... they're not as condescending .. more respectful, definitely and like they would value your judgement ..'
(7/15)

The significance of feeling like part of the team, followed by increased respect and responsibility is also reported in a recent study by Macleod Clark and Maben (1997) who explored Project 2000 as a preparation for practice in nursing.

Responsibility and Autonomy

Implicit in this changing role is a greater degree of responsibility and autonomy. As the students approach the end of the course they actively seek more responsibility and autonomy to provide care. While this is often challenging it is important to learning and preparation for the role of staff nurse. This need for more responsibility and autonomy is also reflected in the changing expectations from the preceptor's role as acknowledged by one student who said:

'I expect to go on to the wards now and be allowed to do a lot more .. maybe have my own patients .. where I can arrange my own work but have a preceptor there just to back me up'
(20/6)

The desire to manage care for a small group of patients, without the direct supervision of the preceptor, is evident. However, as already identified, knowing that the preceptor is available for collaboration should they require it and also for feedback is essential. The influence of increased responsibility on the development

of confidence is well established through the data analysis. One student describes this changing need for preceptor supervision in the following comment:

'They've still got a role to play .. they're still supervising you but it's mair .. unobtrusive maybe .. mair subtle .. they're still aware of what you are doing but they are no shadowing you they give you a wee bit more scope and that gives you confidence in itself' (10/11)

The need to be challenged with greater responsibility was consistently referred to by each of the participants. As well as seeking greater responsibility in delivering direct patient care the majority of students acknowledged the need to develop skill in managing 'the team'. In response to a direct question about expectations from the preceptor the following comment was made:

'more responsibility .. I would like to be given more responsibility as in .. you know getting the chance to manage a team of nurses for the day .. I hope that I'll be able to get the chance to manage a team for the day .. and one of the wards I'm going to is actually quite good because the preceptor actually leaves you .. no doesn't leave you in charge but .. makes you in charge for a day ... so that you're getting the experience and it allows them to see how well you would cope ..' (21/15)

Managing the team involved managing care delivery. The students perceived this as particularly valuable experience. The relevance of such experience is also recognised in recent evaluations of project 2000 courses, where management skills were recognised as a deficit in a number of national evaluation reports, such as those by Runciman et al (1998) in Scotland and Luker et al (1998) in England.

Preceptor as 'Safety Net'

By the end of the course the relationship between student and preceptor has changed. No longer does the student seek the same degree of support and supervision. They now look to the preceptor to provide experiences and allow them to practice on their own.

'the further on you go on the course the less time they spend with you .. that shows they are doing their job properly I think when you get to this stage they are primarily guidance .. they have to let you find your own feet because after all .. in a couple of months time you are going to be a staff nurse there is no much point in taking you by the hand and leading you .. you've got to

learn the difficult way .. it was good knowing there was backup as well ..'

(9/8)

It is evident, however, from each of the participants that the preceptor still plays an important role in providing a 'safety net' which gives them the confidence to push the boundaries of their practice experience. Knowing the preceptor is there, albeit at a distance, is important for student development. Many participants acknowledge their heightened awareness of the need to gain as much experience on their own as possible before course completion. They become acutely aware of the need to feel prepared for the role of staff nurse.

'I mean they (preceptors) don't have to be with you all the time if there is things that you can do obviously you go away and do it yourself .. at this stage it's important I feel to do things on your own because obviously I mean you know that you are going to have to do them yourself when you qualify'

(18/23)

Another student said

'whenever you're registered that's you more or less you're .. you know .. I don't want that feeling of being flung in at the deep end you know whenever I get a job ... you hear about these nurses who have been qualified like three days and they're left in charge of a ward, you know that terrifies me, absolutely terrifies me, whereas if you get that kind of responsibility whenever you are doing your rostered service then it does prepare you a bit more for going out yourself'

(21/16)

Preparation for Registration

The imminence of registration appears to drive the student as they get near the end of the course and this is evident in the focus of learning. In the final year the student becomes more focused on those skills perceived to be needed prior to registration.

'it's just like when you get into your third year you realise that .. oh I haven't done this or this or that .. and I know myself that when I go out for the last twelve weeks I'll be saying, I need to do this ..'

(18/16)

The need to maximise experience is illustrated in the following comment:

'I know it's not long now until I'm out there .. I don't mean this to sound as if I'm scrambling for knowledge at the last minute .. but I feel as though I'm really making a bit of a last push .. you know what I mean .. to get into everything and get as much experience as I can so that when I go out there I am as best equipped as possible' (22/18)

Another student reflected the views of the majority when she said:

'I would rather do it as a part six student than do it as a new staff nurse' (17/12)

Similar findings are discussed by Reutter et al (1997) in a study of socialisation into nursing. The fourth year students in their study would take advantage of their learner role to prepare for future status as graduate nurses. The student nurse status was identified as a justification for admitting 'I don't know'. Learning became focused on the skills needed for the real world. 'The need to prepare for graduate status leads students to become active in seeking out experiences that will increase their confidence. Observation experiences, therefore are not viewed favourably because students feel that these experiences will not prepare them for the work world and may even connote a lack of confidence in the student' (Reutter et al 1997 p.153/4).

Influencing Factors:

Confidence

Many factors which influenced development were described by the students. Without exception, they recognised 'confidence' as a major issue. The need for developing confidence from the beginning of the course and throughout was clearly expressed in the following quotations:

'I think initially and completely ongoing you do need to have confidence building' (6/10)

Another student elaborates on the importance of confidence and demonstrates the link between time, experience and confidence development in:

'time and experience .. I think .. because obviously at first you have got no confidence .. I think as you get more experience as time goes on you build up confidence through feedback from others .. from your own .. you know like if you've done something daft .. you know you've done it .. through feedback from others .. from the college .. from the patients .. experience, now I think that's the most important thing that builds up' (19/12)

The more actively the students participated in care, the more confident they became, a finding supported by Nolan (1998). The work of MacLeod (1996) is of value in understanding the impact of time and experience on the development of confidence. She recognises the complex nature of experience in:

The stream of time influences understanding of current experiences, how previous experiences inform that understanding ... what is understood to be experience with a patient or in a situation, changes. It is the fluid nature of experience which makes it so hard to grasp (p.53).

She goes on to suggest that confidence both comes from experience and forms experience .. part of practising with confidence is drawing on past experience. Within the current study, the need to build confidence through experience is recognised as the student proceeds through the course.

Feedback

Factors which influence the development of confidence vary as the student progresses. At the beginning being allowed to participate and 'getting to do' things with the preceptor is predominant. Feedback and encouragement motivates the students, and stimulates them to continue and subsequently develop confidence in practice. One student acknowledged the effect of feedback on confidence when she said:

'(feedback) .. I think it does stimulate learning .. it gives you confidence .. I think if somebody tells you that you are doing well it gives you confidence and you perform better' (14/16)

Preceptor

The development of confidence is directly influenced by the support of a 'good' preceptor. The continuity inherent in preceptorship influences this development.

The preceptor facilitates access to experience, and knowledge building, allowing the student to move forward as opposed to focusing on repetition of tasks without personal development. This is clearly described in the following student comment:

'because the preceptor knows what you have done, what you are able to do and gives you more guidance and then you can go on and do something else .. because she knows that you are capable of doing it' (25/27)

The continuity provided by having a preceptor is implicit in the above statement. As well as the preceptor, the length of placement is important in continuity of experience. Many participants relate this to development of relationships and the subsequent development of trust. The time taken to establish trust and confidence is influenced by the length of placement and the concurrent access to the preceptor. This is explained in the following comments:

'in the early course parts it was different .. when you were only there for four weeks .. you felt as though you were getting to know where everything was and it was time to leave .. on Monday you were the new student again, it was terrible .. four weeks was just not long enough and there was so much that you wanted to learn .. this has been the best placement because it is longer.. also you are now more confident and you will say what your goals are' (24/6)

The influence of returning to a placement for a subsequent placement is evident:

'because they've known me from before .. they can ask me to do things and leave me to get on with it because they're confident in me and know that if I can't do it I can go back and say .. I can't do this, will you show me she knew what I was capable of and hoped that I had built on it' (6/12)

Trust

The influence of trust on development is implicit in the latter comment and acknowledged throughout the study. Continuity as well as responsibility for facilitating learning, allows the preceptor to get to know the student and begin to trust them to do certain things. Gaining the trust of the preceptor becomes very important to the student as reflected in the following comments:

'I can honestly say that most of the preceptors I've had have helped me to do that (link theory to practice) and it's allowing you to do things like that .. also in trust to .. getting to the end and feeling that your preceptor is trusting you

to do things makes a big difference to your confidence ... overall the preceptor is the one that's going to say to you .. I want you to do this, I want you to do that and they're the ones that can help you build your confidence'
(8/15)

The influence of the preceptor was elaborated on frequently. Another student said:

'They made me feel worthwhile .. they made me feel as if I was equal to them They were giving me knowledge that they had .. sharing experiences with me .. and allowing me to develop my own self worth .. and the difference that makes is tremendous, because you can go in the morning and you can .. you think well I can do .. or you can plan what you are going to do because you know that that person will do what they can to facilitate that learning experience for you and it makes a tremendous difference'
(6/7)

This statement is supported by many students and the impact on self worth is evident. Increased self-concept or confidence has been reported as an outcome of preceptorship experience in previous literature (Dobbs 1988; Scheetz 1989; Ferguson and Calder 1993).

Self Esteem

Confidence is closely related to self esteem and self worth throughout the data. As the individual begins to feel confident they begin to feel good about themselves and as such develop in self worth. As self worth develops confidence grows. This finding is supported by the work of Chally (1992) who links positive self concept to empowerment in learning and states 'In order to learn an identified goal, an individual must believe that he or she is capable and worthy' (p.119).

Personal Development

Given the course extends over a three year time span, ongoing personal as well as professional development is evident. A number of the younger participants acknowledged their own personal development as 'growing up' and changing through the experience of practice. One student explained this in the following comment:

'I think you have got to grow up an awful lot as well .. because I was only seventeen when I started .. I've grown up an awful lot I think .. more caring .. you see a lot of things that you've never seen before ...' (19/9)

Another student said:

'I've grown up a lot .. aye definitely, I mean I was always told at school that I was quite mature for my age but since I came to college I have grown up a lot more and you square your head on and you think oh well I really need to know this and I really need to learn that and get the head stuck down and get things done .. as well as becoming more assertive ... I have changed quite a bit as well .. I've got a lot more common sense now than I ever had .. yea every placement my confidence has been boosted that wee bit more' (21/20)

These comments reflect the degree to which individual students perceive themselves as changed. Becoming self confident was recognised as an achievement by the majority of participants as they came to the end of the course. Another student identifies the impact of experience in:

'I'm much more confident and I've become more assertive, I'm not afraid now to say what I think ... being allowed to do things, experience (has helped confidence development), feedback from your preceptor and all the other staff and your lecturer. In this placement going out on your own and being allowed to do things' (24/25)

This student recognises a variety of influences on development. Daloz (1986) suggests that the proper aim of education is to promote significant learning and significant learning entails development. At the heart of development is trust, a willingness to let go. He goes on to advise that such trust rarely happens in a vacuum and that we need other people with whom to practice that trust (p236). It would appear from the current data that the preceptor has the potential to facilitate student learning through the development of a trusting relationship in which the student develops both professionally and personally.

5.7 Summary

This chapter has provided an extensive, mainly descriptive, account of the student experiences. The themes of: preceptor; learning environment; student needs; process of learning; and process of development have been analysed and presented to illustrate a breadth of understanding from the students accounts of their experience of preceptorship. The following chapter will present an interpretive discussion, within which a framework of explanation is brought to the data. Drawing on the student experiences, the aim is to add depth to the knowledge and understanding of the practice of preceptorship. In Sandelowski's (1995) terms the analysed data will be construed in such a way that something new is created that is different from, yet faithful to, the data in its original form.

CHAPTER 6

CHAPTER 6

DISCUSSION

6.1 Introduction

Within the previous chapter the themes emerging from the data have been described, discussed, and to a limited extent, explained. The aim of this chapter is to present an interpretive analysis of the findings using existing theories of learning and cognitive development. The sociocultural theories of learning and development, which were introduced in chapter 3, will now be drawn on extensively to provide a framework within which the student experience of preceptorship and learning in clinical practice are explained.

Using this sociocultural framework the interpretive analysis will be presented in two sections. Firstly, 'entry into the clinical environment' will be interpreted and explored with reference to '*legitimate peripheral participation*' (Lave and Wenger 1991). Then, 'the process of learning' will be analysed and interpreted within the framework of *guided participation* (Rogoff 1990). The implications for understanding preceptorship and the influence on student learning will be explained. A summary of the findings, themes and theoretical framework will be presented before the interpretative analysis.

Background

Looking back on the approach to the study, and in particular the watershed between the two phases of data collection, an important methodological change was introduced. Until this point the principles of grounded theory were guiding the study. The rationale for change in direction was based on the questions and issues arising from the analysis of data in the first section and is explained on page 101. Many of the questions which arose from the first phase of the study were answered

through the continued process of theoretical sampling and constant comparative analysis. Nevertheless, other questions and issues emerged which guided the analysis towards existing theories of learning in search of explanation and understanding of the student experience. A summary of findings and themes will now be outlined prior to presenting the interpretive analysis.

6.2 Findings and Themes

Three main findings emerged from the first phase of data collection:

- Students have a need to 'fit in' and feel comfortable before they can focus on learning from practice. When they feel comfortable they are more likely to adopt a deep approach to learning. The preceptor influences the 'fitting in' process.
- The degree of structure in a placement influences student learning. The preceptor who organises a planned programme for the student positively contributes to the learning experience.
- The nature of the preceptor student relationship changes over time. As the student's needs change, the preceptor's role changes.

Summary of Findings

Without exception the participants acknowledged the positive effect of 'having someone there' in the clinical area. Both positive and negative experiences of preceptorship were identified and related. Even when the experience was described as negative, for example, when the student preceptor relationship was difficult, it was still important to have a name, someone to go to should any problems be encountered. The quality of the learning experience was however influenced by the individual preceptor and the relationship formed.

The need to 'fit in' and feel comfortable within the clinical area was crucial to the outcome of the learning experience. The 'good' preceptor played an important role

in assisting this process as well as facilitating learning through providing structure, guidance, supervision, support and challenge. The roles of preceptor and student were dynamic, changing to a certain extent within each placement but to a greater extent over the three year course duration. As the student developed in confidence and competence, the preceptor moved from role model to supervisor, facilitating greater opportunity for collaborative and autonomous practice. The students clearly identified the need for more responsibility and actively sought to become more autonomous in their practice as they progressed. They looked to the preceptor to provide the experience and the support they required to enact the role. The changing role was perceived by the students as essential to the development of professional competence and confidence to practice.

Themes

In addition to these findings the following key themes persisted throughout the study:

- The relationship between the dynamic nature of preceptorship and the process of professional and personal development in the student.
- The influence of the preceptor/student interaction and the significance of speech and communication on knowledge building in practice.
- The changing need for support and challenge as influences on learning.
- The limited extent to which social learning theories such as role modelling were useful in explaining the influence of preceptorship on learning.

The complex nature of learning in practice was emphasised when exploring the themes highlighted above. One persistent question: *'to what extent can these findings be explained through other theories of learning and cognitive development?'*, subsequently changed the direction of the study and led towards analysis of existing bodies of knowledge. The findings would not fit readily into a narrowly cognitive theoretical framework. Nor would a social learning framework allow for understanding of the complex nature of learning. While there was evidence of role modelling, from a theoretical perspective this was insufficient to explain the student experience of preceptorship. It was felt that other theorists would add more

light and that these key themes could then be more fully understood when related to existing theories. Analysis of the sociocultural theories of learning derived from the work of Vygotsky allowed for a framework of explanation to be brought to the data. This change in direction, and the introduction of an explanatory framework, was crucial to the development of understanding of preceptorship and the process of learning in practice.

6.3 Theoretical Framework

The student experience of preceptorship occurs within a social context of clinical practice and is based on a relationship between an individual student and an experienced nurse. It was therefore important to identify and explore the extent to which both context and social interaction influenced the student experience.

The role of the preceptor and the important influence of the environment on learning guided the search for explanation to the existing literature on social and cultural influences on learning. More specifically, the concepts of guidance and participation, which emerged from analysis as critical to the process of learning, stimulated a literature search which led to the work of Rogoff (1990). The concept of 'guided participation' was identified and developed by Rogoff to explain how children's development occurs through active participation in cultural systems of practice. Rogoff's theory derived from and extended the seminal work of Lev Vygotsky and the socio-cultural field of literature. Consequently, the present study was guided towards exploration of this particular body of knowledge.

Vygotsky (1978), and more recently Rogoff (1990), argue that everyday human learning is a context dependent and socially mediated activity. Vygotsky's early work, as described on page 49, stresses the relationship between social interactive and higher mental processes, identifying the linguistic mediation of both kinds of processes. Analysing the student experience, the importance of language emerged throughout the data as essential not only to the development of the relationship

between preceptor and student, but also to the process of learning. The participants consistently identified the importance of *'talking through'*. Describing the experience of working with a good preceptor a frequent comment was: *'they talked you through whatever they were doing'*. It was this process of *'talking through'* concurrent with practice and activity which was identified as crucial to learning and developing understanding. The linguistic mediation between social interactive and higher mental processes as described by Vygotsky is critical to the explanation of, and the significance, of *'talking through'* and will be explored further. As well as *'talking through'*, *'fitting in'*, *'getting involved'* and participating in care delivery were essential to the process of learning. The following interpretive analysis will draw on the work of Vygotsky, as well as Lave and Wenger to explain the process of entry, and *'fitting in'*, to the clinical environment. The processes of participation, communication, collaboration and development will then be interpreted with reference to Rogoff's theory. Subsequently, understanding of the student experience of preceptorship and the influence on cognitive development and *'becoming'* a nurse will be extended within this sociocultural framework.

6.4 Entry Into the Clinical Environment

Fitting In

The need to *'fit in'* to the clinical environment before focusing on learning is evident from the recurrence of comments such as:

'everywhere you go you've got to fit in' (6/30)

'Fitting in' has been a consistent theme throughout the study and reinforces the findings of Melia (1981; 87). Melia's study was carried out in a different nursing education climate, with no formal support systems in practice and *'fitting in'* constituted a major part of the student behaviour. This constant thread in Melia's study was closely linked to the students' need to meet the expectations of those they worked with. Ward sisters, trained nurses and untrained staff often had different expectations which the student had to accommodate. While the students in the current study still recognise *'fitting in'* as a priority when going to a new clinical

area, the length of time involved in this process is markedly reduced when assigned to a good preceptor. The 'good preceptor' clarifies expectations at the outset, identifies learning goals and prepares a plan or programme to meet these goals. When this happens the students are supported in the clinical area, they 'fit in' and feel more comfortable, anxiety is reduced and they can focus on learning from practice.

The review of Vygotsky's work on page 58 highlights the influence of support systems in learning. In particular he acknowledges the role of the 'tutor' on an individual's development as well as the impact of interaction with more competent persons. Lave and Wenger (1991) draw on Vygotsky's theories and focus on support systems to explain the influence of a 'sponsor' on a newcomer's learning when entering a new environment. As learning involves entry into a culture and is influenced by induction from more skilled members, Vygotsky's theory and the work of Lave and Wenger help to untangle the complex processes emerging from this study, in particular the process of 'fitting in' and the influence of the preceptor.

6.4.1 Legitimate Peripheral Participation

Lave and Wenger (1991) argue that learning can only take place when individuals are sponsored into an unfamiliar community of practice by an experienced practitioner and inducted into its everyday (informal) knowledge and practices through 'legitimate peripheral participation'.

Legitimate peripheral participation denotes:

the particular mode of engagement of a learner who participates in the actual practice of an expert, but only to a limited degree and with limited responsibility for the ultimate product as a whole (p.14)

According to Lave and Wenger (1991), 'legitimacy' is a defining characteristic of ways of belonging and therefore a crucial condition for learning. When the students in the current study were assigned to a 'good preceptor' this clearly influenced their

own role perceptions, they 'felt like a student' with certain 'things' to achieve. This happened when the preceptor established a relationship with them, identified learning goals and provided a plan or structure for the placement. In Lave and Wenger's terms this legitimised the student role. 'Legitimacy' underpins the importance of the 'student' role, as described by the participants in this study, and how having a preceptor can 'legitimise' the role. This finding adds an important contribution to the ongoing debate in nursing education regarding the 'supernumerary status' of students. This debate has continued since the implementation of the Diploma of Higher Education in Nursing and may be informed by the analysis of the students' perception of their role identified in this study.

The issue of role emerged as significant throughout the data analysis. The participants frequently made comparison between the 'positive' experiences of preceptorship in which they felt like a student with clear learning goals and the more negative experiences where their role was less well defined. In absence of the preceptor, the student often described 'feeling like an auxiliary' or being 'just a pair of hands' in which case learning was of secondary importance to getting the work done. Having a preceptor not only influenced the 'legitimacy' of being in the clinical area to learn, but also the extent to which the student was involved or peripheral to the practice of nursing.

Legitimate peripherality is recognised by Lave and Wenger as a complex notion, implicated in social structures involving relations of power. Peripherality is an empowering position when used in a situation in which one moves towards more intensive participation:

the partial participation of newcomers is by no means 'disconnected' from the practice of interest. Furthermore, it is also a dynamic concept. In this sense, peripherality, when it is enabled, suggests an opening, a way of gaining access to sources for understanding through growing involvement (p.37)

As well as recognising 'peripherality' as an empowering position, Lave and Wenger also acknowledge that peripherality may be a disempowering position when one is kept from participating. If we consider nursing as a community of practice into which students aspire to enter, then this work is useful in unravelling and explaining the experience of students in the present study entering a new clinical placement, the process of 'fitting in' and the influence of the preceptor on the complex process of learning.

The support and continuity provided by a named practitioner is a major development in the clinical experience of the student nurse. In the context of earlier studies such as those of Olesen and Whittaker (1968) and Melia (1981) no formal support systems were in place. As the students were considered part of the work force, employed to provide service while training, it could be assumed they were more full participants in nursing care than the students in the present study. It is evident from Melia's study, however, that the transient nature of the students' experience resulted in the frequent denial of information about patients and the description of the experience as 'working in the dark'. In the absence of a 'sponsor' to share the responsibility for achieving specific learning goals, the students adopted behaviours or strategies to gain acceptance by the staff with whom they would be working and focused on meeting a range of expectations which differed from individual to individual and from clinical area to clinical area. Furthermore, in light of Lave and Wenger's theory, peripherality may have prevented those students from fully participating in care delivery and thus placed them in a disempowering position. Billet (1998) also recognises that those 'full participants' (expert practitioners) are in a position to either inhibit or permit access to activities by peripheral participants. The influence of the preceptor on student involvement in nursing care and access to experience is thus recognised.

Another important factor arising from these early studies in nursing relates to the amount of time the student nurse spends working with auxiliaries. In fact in Melia's work the interchangeability of students with auxiliaries was a recurrent theme. Not

only did the auxiliary play a significant role in the socialisation process of the student, but also in the teaching of the students. Participants in the current study also acknowledged the significant role played by the auxiliaries and the amount of time they spent working together. However, when assigned to a 'good' preceptor, they were not quite so reliant on the auxiliary because they knew what was expected from them. They still worked with the auxiliary, but they had a programme or plan in which expectations were clearly communicated and learning goals were structured.

The fundamental activity of sponsorship in legitimate peripheral participation as described on page 61, allows learning to start by reducing feelings of alienation and increasing eagerness to learn. In the work of Lave and Wenger, the sponsor is responsible for structuring the activity to allow the student to participate at a level which enables them to engage in the practice depending on their readiness. In the context of the present study this involved the students 'working' with the preceptor, observing or undertaking some of the associated or component parts of the nursing care, alongside, and while the preceptor was also actively involved in the care giving. This collaborative activity, where the care was undertaken together, was an essential feature of the learning process. The continuity provided by the preceptorship allowed for the development of a relationship which facilitated the student's move towards more intense participation.

In the context of nursing, Spouse (1998) acknowledges that when working alongside a sponsor, the newcomer's learning needs and readiness to undertake aspects of care independently can be assessed. Moreover, she goes on to advise that: 'legitimate peripheral participation is not concerned with dogged affiliation to one member of the community, it concerns the whole community' (p.349). This effectively permits the student to become an acknowledged member of the whole community, which should be engaged in promoting the well being and development of newcomers.

Spouse recognises that through engagement with an experienced practitioner, a novice is able to observe and note the more subtle and indescribable artistic and

therapeutic aspects of care giving. These include: the nuance of voice, attention to detail, how information is presented to meet needs, as well as the effective adjustment of care practices to suit the individual patient. This is consistent with Shotter's view of the social relation as instructional, as described on page 53. The instructional nature of the relationship identifies the questions which evolve from the practice. The way in which these questions are formulated, prioritised and addressed in themselves and by the individual communicates underpinning attitudes and values towards the particular reality. The engagement between preceptor and student therefore influences not only cognitive but affective development.

Within this current study preceptorship provided the student with a sponsor responsible for facilitating learning within the clinical area. The preceptor enabled the student to participate in a legitimate role. When assigned to a 'good preceptor' the student recognised the positive impact this had on 'fitting in' to the environment. The preceptor was seen as a vehicle for entry into the environment. This reduced the 'fitting in' period and associated feelings of alienation, allowing for an earlier focus on learning and access to relevant experience. Without exception the participants recognised the need to be involved in care delivery and acknowledged the 'good preceptor' as someone who does involve them, someone who takes time to show and talk through what they are doing. In describing the experience of preceptorship the most important factor was 'having someone there'. Using the words of Lave and Wenger this legitimised the student presence in care practices. Not only did the student have a legitimate role to play in care delivery, but also was legitimised as someone who was there to learn. The quality of the relationship between preceptor and student, however, influenced the quality of the learning experience.

Summary

Understanding of the process of 'fitting in' is widened and deepened by viewing it within the framework of legitimate peripheral participation. The central notion of sponsorship allows the student to work with an experienced practitioner in the daily practices of care giving. Throughout each clinical placement the student is learning

not only specific knowledge and skills but also language, cultural practices, values and beliefs. Spouse (1998) argues that through peripheral participation in activities alongside their supervisor and later on their own, students are able to become part of the community of a clinical placement with its own specialist knowledge. The influence of participation on learning was recognised as far back as 1916 when Dewey said:

The social environment .. is truly educative in its effects in the degree in which an individual shares or participates in some conjoint activity. By doing his share in the associated activity, the individual appropriates the purpose which actuates it, becomes familiar with its methods and subject matters, acquires needed skill, and is saturated with emotional spirit (p.26)

While legitimate peripheral participation may serve as a useful framework for explaining entry into the community of practice and access to cultural knowledge, it is not in itself sufficient to account for the cognitive development of students in nursing. Recognising the need to stimulate critical thinking and facilitate development of the cognitive skills required to examine nursing practice critically, the work of Rogoff (1993) on guided participation will now be drawn upon. The aim is to explore the process of cognitive development further, to identify the cognitive activity embedded in learning from practice and to illustrate the implications for understanding preceptorship. The following section therefore moves on from the initial entry into the clinical environment to interpret and explain the processes of participation, collaboration, communication and development.

6.5 Process of learning

Introduction

The influence of legitimate peripheral participation as well as the different types of learning identified in the above quotation by Dewey are clearly evident in the following account by a student in the present study:

'we had a lady admitted to the ward, she was a manic depressive, but she was in her manic stage .. really manic .. and learning how to cope with that .. it wasn't really the time .. you couldn't say to your preceptor .. well, could you just stop in the middle of this and explain to me about this procedure .. It was just a case of getting talked through it, and my preceptor was excellent, it was a case of .. now this is what we are going to do .. you do this, I'll do that .. and we did it, and we were with that woman for nearly the whole shift .. and we never really had the chance to discuss things because we were just dealing with her constantly ... when we finished on the shift she said, how do you feel about that? and she talked to me, probably staying a wee bit longer than she had to .. then she said .. go home and read your text book on manic depression .. not it all .. just bits and pieces that you think link in with today and we'll discuss it on Monday..' (8/12)

Not only does this account capture the importance of legitimate participation, but also more complex interpersonal and collaborative processes involved in learning from practice as well as the significance of the preceptor's role. This student went on to explain how much he had learned from this particular experience. Being with the preceptor allowed the student to be involved in this unpredictable learning situation, embracing, to some extent, the emotional spirit of nursing practice. The preceptor treated the student as an individual, recognising his learning needs in the midst of this intensive nursing situation. The relationship with the preceptor not only facilitated the student presence but also the interaction which guided and linked nursing theory and practice. The continuity within preceptorship allowed for immediate reflection as well as discussion and feedback at a more appropriate time following the experience. The complex processes involved in learning will now be explored further.

6.5.1 Guided Participation

Within the theoretical framework the work of Lave and Wenger was limited to explaining the process of entry into the clinical environment. To extend understanding of the student experience of preceptorship the process of learning is explored further and interpreted using Rogoff's theory of 'guided participation'. According to Rogoff (1990), guided participation involves children and their care

givers in collaborative processes of building bridges from present understanding and skill to reach new understanding and skills. This involves arranging and structuring participation in activities, with dynamic shifts over development in children's responsibilities. She considers development as including transformations in thinking that occur with successive attempts to handle a problem, even in a time span of minutes (microgenetic development). This is in addition to those transitions which occur across the years of an individual's life (ontogenetic development). While Rogoff suggests that both guidance and participation in culturally valued activities are essential to children's development, this current thesis explores the idea that similar activity is essential for students of nursing to develop the knowledge, skills and values required to become competent practitioners.

Collaboration

The collaborative engagement central to guided participation offers some degree of explanation and understanding of the complexity of learning from practice. Guided participation demands collaboration between novices and more experienced individuals. In contrast to information giving as the exclusive vehicle for learning, guidance is offered as the more experienced or resourceful person interacts, participates and engages in practice with the less experienced. Involvement in everyday activities is crucial to individual development. Preceptorship aims to provide the student with access to the everyday practice of nursing with guidance and support of an experienced practitioner.

Guided participation, as described by Rogoff, involves both direct and indirect everyday activity as individuals engage with one another. It includes deliberate attempts to instruct as well as incidental comments and tacit behaviours. While participation requires engagement in some aspect of the shared endeavour, Rogoff suggests that it does not necessarily have to be a joint activity:

A person who is actively observing and following the decisions made by another is participating whether or not he or she contributes directly to the decisions as they are made Guided participation is thus an interpersonal

process in which people manage their own and others' roles, and structure situations (whether by facilitating or limiting access) in which they observe and participate in cultural activities. These collective endeavours in turn constitute and transform cultural practices with each successive generation
(Rogoff 1995 p.148)

This quotation highlights the complex nature of guided participation and the significant activity involved. Implicit within the process is the ongoing assessment and reassessment of an individual's readiness to become involved. Collaboration and communication are essential elements in reaching shared understanding. Learning is reciprocal, in that the experienced individual is reassessing his or her own position in light of the interaction with the other. The paradox of this statement may be explained with reference to Dewey (1916) who said:

. . . all communication is educative. To be a recipient of a communication is to have an enlarged and changed experience. One shares in what another has thought and felt .. has his own attitude modified. Nor is the one who communicates left unaffected .. communicating with fullness and accuracy, some experience to another .. you will find your own attitude toward your experience changing ... the experience has to be formulated in order to be communicated. To formulate requires getting outside of it, seeing it as another would see it, considering what points of contact it has with the life of another so that it may be got into such form that he can appreciate its meaning (p. 8/9)

The collaborative nature of guided participation, and the inherent learning and development of both the novice and more experienced individual takes the analysis of learning in practice beyond that of role modelling. While social learning theory is useful in explaining the processes of observation and modelling, guided participation incorporates the direct and indirect participation in problem solving and decision making which involves dynamic shifts in responsibility in response to situations and individual development. Guided participation is therefore used to explain the changing nature and reciprocity identified in the preceptor-student relationship.

Guided Participation and Tacit Learning

Rogoff highlights the significance of observation in everyday situations to the process of development. Similar behaviours to those recognised by Rogoff in

facilitating learning are described by the students in the current study. The influence of observation and collaboration in daily activities was clearly and consistently acknowledged. When the students work with a 'good preceptor', the preceptor gets to know them, recognises their level of development and 'allows' them to participate at increasingly more complex levels as they develop in competence. The preceptor often segments care into manageable components in order to allow the student to participate and progress in the development of skill. This arrangement for facilitating learning was often a tacit process with the preceptor or other experienced nurse unaware of specifically instructing but using situations opportunistically to involve, guide and indicate critical factors or alternatives. In clinical practice, the preceptor and student collaborating in care delivery are very often unaware of the extent of teaching and learning, as one student commented: *'when you are working with the preceptor you are learning but you don't feel as if you are being taught constantly'*. As well as providing access to activities and thereby arranging the occurrence of cognitive tasks, Rogoff acknowledges that adults facilitate children's learning by regulating the difficulty of tasks. She also highlights the tacit nature of learning from verbal and non verbal interaction. Analysis of the students' experience of preceptorship reflects similar features.

Support and Challenge

Guided participation involves adults challenging, constraining, and supporting children in the process of posing and solving problems 'through material arrangements of activities and responsibilities as well as through interpersonal communication' (Rogoff 1990 p.18).

Rogoff recognises support and challenge as 'social resources' which children use for guidance in assuming increasingly skilled roles in the activities of their community. This again reflects the experience described by the participants in the current study and their perceptions of the preceptor role. Students identify the need for both support and challenge from preceptors and other staff in developing their skill and

competence to practice. They perceived the preceptor's role to involve supporting and challenging in order to facilitate learning.

As well as recognising the need for support and challenge the predominance of one over the other changed as the student progressed through the course. The need for support was recognised as predominant in the early course stages, but as the student developed in confidence and competence the need for challenge was recognised more positively. The students' positive response to challenge is reflected in their increasing self confidence which in turn motivates and stimulates further learning. The 'social resources' of support and challenge were therefore utilised in the context of practice for guidance in assuming increasingly skilled roles.

Structure

In addition to support and challenge, the participants recognised their positive response to structure in their clinical practice. Once again this is consistent with Rogoff's theory. Rogoff elaborates on Vygotsky's approach by providing more focus on the role of children as active participants in their own development. She acknowledges that children seek structure, and even demand the assistance of those around them in learning how to solve problems, they actively observe social activities, participating as they can. Again, while this work is focused on child development evidence from the current study suggests that adults use similar strategies in a new learning situation. Particularly in the early course stages, students expected and needed some form of structure to the placement. They identified the good preceptor as someone who provided structure, usually in the form of a planned programme. This programme provided a vehicle for communicating and clarifying expectations. It made explicit the experiences available and this reduced anxiety. The students, as adults, were encouraged to identify their own learning needs and to accept responsibility for meeting these needs. However, they frequently proclaimed that it was only as they developed, and in the latter course stages, that they became more proactive in seeking experience and demanding assistance in meeting learning needs.

Scaffolding

The structure expected in the early course stages could be seen as one illustration of 'scaffolding' as described by Wood et al on page 57. The programme or plan constructed by the preceptor was based on the individual student's personal and curricular needs. The level of involvement in specific procedures or nursing practices was altered as the student developed. The preceptor engaged with the students allowing them to participate with support and supervision. Viewed from a more theoretical perspective they could be seen to be 'constructing' and 'deconstructing' a supportive 'scaffold' as required. This allowed the student to extend current skills and knowledge to a higher level of competence, gradually increasing their level of involvement with both direct and indirect support from the preceptor. The students frequently contrasted their experience of 'shadowing' the preceptor in the early course stages to 'letting go' in the final placements. As they gradually assumed more responsibility for different skills and practices, they 'let go' of their dependence on the preceptor. However, the knowledge that the preceptor was there as a 'safety net' reduced anxiety and continued to provide support.

Transfer of Responsibility

The movement described in 'shadowing' to 'letting go' illustrates the dynamic nature of the preceptor student relationship and the transfer of responsibility. Transfer of responsibility is emphasised by Rogoff in the management of situations which ensure a challenging but comfortable level of participation for children. Preceptorship is dynamic in nature with ever changing roles for both the preceptor and the student. Central to this changing role is the transfer of responsibility between preceptor and student. In the positive experiences of preceptorship, the students describe how the preceptor gets to know them, realises their individual stage of development and responds by increasing access to appropriate and higher level skills. The preceptor increasingly transfers responsibility to the students by allowing them to carry out care without direct supervision. In this way the student experience in skill and knowledge progresses. Participants clearly identify the need for more responsibility as they develop on the course. They actively seek to become more autonomous in

their practice and look to the preceptor to provide the experience and the support required to enact the role. The influence of responsibility on the development of confidence in nurses is previously recognised by Macleod (1996) who explained:

Having responsibility with support seems to be a key to developing confidence. It engages the nurse in the situation and engenders the commitment and involvement required to take action which, in turn, opens new ways of noticing and understanding (p.130).

Relationship

The introduction of preceptorship aims to encourage collaboration in problem solving and therefore, I would suggest, could influence the difference between a student's actual development and potential development in performance. In Vygotsky's terms, the preceptor provides the support system that helps the learner move through his or her 'zone of proximal development' to reach higher ground mentally. As Bruner (1985) reminds us: 'there must be at any given stage of voyaging into the zone of proximal development a support system that helps learners get there' (p. 32). However, analysis of the present data highlights the significance of the relationship between preceptor and student. The distance between actual and potential development will therefore be affected not only by the individual's development and intellectual position, or the provision of a support system per se, but also by the interpersonal relationship established between preceptor and student.

The significance of the relationship between preceptor and student is clearly evident in the present study. When the student feels comfortable in the relationship she is more relaxed and more receptive to the guidance and feedback from the preceptor and in turn more open to learning. The importance of the relationship should therefore not be underestimated. Pridham et al (1998) suggest that guided participation in general concerns: 'bringing a novice over time into full participation in a practice, or pattern of activities which are routinely or repeatedly performed to accomplish a socially meaningful goal' (p.950). Guided participation occurs through a relationship in which the guide is also learning about the activity and what is

needed in respect to the novice's development of competencies. The preceptor must be skilled in assessing student performance and stage of development in order to structure the experience to meet individual needs. Vygotsky argues that:

instruction is good only when it precedes development. It then awakens and raises to life those functions which are in a state of maturing and which lie in the zone of proximal development (p.86).

Each of the participants in the study identify the significance of their relationship with the preceptor to the outcome of the placement. Indeed, a positive relationship with the preceptor is perceived as crucial to the quality of the learning experience. A major factor in the development of the relationship, however, is the length of the students' placement. Time is required for the preceptor and student to get to know one another and to establish trust and confidence. Short placements do not facilitate this process. Consequently, the degree to which the preceptor will involve the student, or trust them to carry out care without direct supervision, may be limited in a short placement. Time is required for the preceptor to assess the students' level of competence, their strengths and their limitations, so that transfer of responsibility can be gradually and safely increased. The length of placement is therefore important to the development of a relationship in which the preceptor can structure the experience in a way that will maximise the students' participation and collaboration in nursing care.

Participation and Appropriation

Communication and co-ordination with other individuals is essential to development of understanding. The search for common ground between preceptor and student involves adjustment and growth in understanding. Rogoff (1995) uses the term 'participatory appropriation' when referring to the process by which individuals transform their understanding of, and responsibility for, activities through their own participation. She goes on to explain:

through participation people change and in the process become prepared to engage in subsequent similar activities. By engaging in an activity,

participating in its meaning, people necessarily make ongoing contributions (whether concrete actions or in stretching to understand the actions and ideas of others). Hence, participation is itself the process of appropriation (p. 151)

Utilising Rogoff's theory of guided participation and associated participatory appropriation, the impact of the preceptor student relationship on cognitive development begins to emerge. Rogoff explains how a person participating in an activity is part of that activity, not separate from it. Appropriation occurs in the process of participation. As the individual changes through involvement in the situation, this participation contributes both to the direction of the evolving event and to the individual's preparation for involvement in other similar events. Therefore, 'Appropriation is a process of transformation, not a precondition for transformation' (p.153). According to Rogoff, this is a process of *becoming*, rather than acquisition - in Shotter's terms, an ontological as well as an epistemological process. If we consider the student nurse and the preceptor as interdependent social partners, whose roles are active and dynamically changing, the specific processes by which they communicate and share in decision making become the substance of cognitive development and essential to the '*becoming*' of a nurse.

'Becoming' Ontology or Epistemology?

The significance of 'becoming' is also recognised by Shotter (1993b). He argues that 'internalisation' of knowledge cannot be just to do with action it must also be concerned with the development of one's being as a proper member of one's society. He considers the influence of language on learning and claims that although words can be used in a 'tool-like' way, as a means of 'shaping' meaningful speech and action, they cannot just be used as we please; these 'enablements' are also constraints upon our forms of being. They exert an ontological as well as an epistemological influence on us. He goes on to suggest that reinterpreting internalisation in this way leads us to a new view of it (I would suggest a view consistent with Rogoff's 'appropriation' which is discussed above) i.e. it is not a process in which what is at first outside us simply comes to be incorporated within us. Nor does it simply create an internal 'plane of consciousness' as claimed by Leont'ev (1981):

Instead, it suggests that we must learn how to be properly thoughtful and autonomous members of our society, how to see and hear things as others do, how to link our actions to theirs in acting in a socially intelligible and legitimate way. It is the development of this kind of (practical-moral) knowledge - of how to be an individual of a certain socio-cultural kind - that is a major part of what is involved in this version of 'internalisation' ... This is why an ontological rather than an epistemological issue is at stake (Shotter 1993b, p.62)

In relation to this current thesis Shotter's argument serves to assist in understanding the student's priority of being accepted into the nursing culture. There is an ontological issue at the centre of preceptorship. The student is learning not only how 'to do' what nurses do but also how 'to be' a nurse. This accounts for the development of attitudes and values as well as the development of knowledge and skill.

Communication and Learning

The relationship between participation and appropriation is evident in the previous discussion. The influence of communication on participation is a constant thread throughout this study. The participants clearly acknowledge the use of speech in controlling and directing behaviour. When working with a preceptor the student depends on the preceptor to 'talk through' what they are doing. The impact of the preceptor student relationship in such an interaction is recognised in the previous sections. However Shotter (1993b) adds another dimension to this discussion when explaining the complexity of learning within a situation:

the expression of a thought or an intention, the saying of a sentence or the doing of a deed, does not issue from already well formed and orderly cognitions at the centre of our being, but originates in a person's vague, diffuse and unordered feelings - their sense of how, 'semiotically' they are positioned in relation to the others around them (p.63)

Shotter goes on to explain the development of a set of temporally conducted transactions within which orderly expressions are negotiated in a back and forth process between the people involved, where each tests the other as to the social

appropriateness of their attempted expressions. Shotter supports his suggestion by referring to Vygotsky who said:

A speaker often takes several minutes to disclose one thought. In his mind the whole thought is present at once, but in speech it has to be developed successively .. because thought does not have its automatic counterpart in words, the transition of thought to words leads through meaning
(1988 p.251)

This discussion is consistent with Dewey's view that meaning is a social construction. According to Dewey:

.. the fruit of communication should be participation, sharing, is a wonder by the side of which transubstantiation pales .. when communication occurs, all natural events are subject to reconsideration and revision; they are re-adapted to meet the requirement of conversation, whether it be public discourse or the preliminary discourse termed thinking (Dewey 1925/1981 p. 132)

Preceptorship provides a vehicle for student entry into the clinical environment and a basis on which to develop a collaborative relationship. The collaborative process central to guided participation facilitates the development of knowledge and understanding through participation in practice. Interpersonal communication provides the social origins for *intrapersonal* speech as described by Vygotsky, which is required for the promotion of higher mental functions such as problem framing and solving.

Problem Solving

Participating in actual care delivery both with experienced practitioners and on their own involves students in everyday problem solving activities. Involvement in such activities is recognised by the participants as essential to their learning. In Rogoff's view development includes transformations in thinking that occur with successive attempts to handle a problem. Billet (1998) identifies the close relationship between problem solving and learning recognised within both the sociocultural and cognitive perspectives on learning. He goes on to elaborate:

common to these perspectives is that problem solving transforms individuals' existing knowledge structures. Routine problem solving reinforces existing structures, whereas novel or non routine problem solving transforms knowledge and, in doing so, extends the individuals' cognitive structures which permit performance (p. 257)

As the students in the present study progressed they became more actively involved as members of the nursing team. This involvement allowed them to use their existing knowledge in goal directed activities (problem solving) and in decision making. When a positive relationship was established with the preceptor this provided a basis for more collaborative problem solving and decision making. The ongoing feedback in such a relationship affirmed the students' performance and progress which again influenced learning and development of confidence.

6.6 Summary

Vygotsky's model for the mechanism through which social interaction facilitates cognitive development resembles apprenticeship, in which a novice works closely with an expert in joint problem solving within the zone of proximal development. The novice is thereby able to participate in skills beyond those that he or she is independently capable of handling. The novice develops through the shared cognitive processes, appropriating what was carried out in collaboration to extend existing knowledge and skills (Rogoff 1990 p141).

The work of Lave and Wenger has been used to explain the process of entry into a new cultural situation and the impact of sponsorship on learning. Rogoff's (1990/1993) work was then introduced to explore the notion of guided participation within the context of nursing. While Vygotsky and Rogoff focus primarily on cognitive development in children it is suggested that their work provides a useful framework in developing understanding of adult learning and development in new cultural contexts. Reflecting on this work it is suggested that strategies used by children to learn and develop as mature individuals in society are also used by adults in new cultural circumstances.

Rogoff (1990) identifies the cognitive with the sociocultural aspects of learning. She links activity with problem solving when she argues that it involves interpersonal and practical deliberations in goal-directed activity. As individuals engage in goal-directed activities, they access, manipulate and transform cognitive structures which are socially sourced resulting in the construction and organisation of knowledge. So, central to this appropriation, are routine and non routine problem-solving activities in everyday practice, because both problems and their solutions are socially determined.

The current thesis acknowledges the complex process involved in learning through clinical practice. The overall aim of preceptorship, to facilitate student learning, relies on understanding the process of learning and the influence of this complex environment. Preceptorship provides a formal system of support for students during periods of clinical practice. This allows for an inexperienced student to work with a more competent nurse over a period of time. The continuity facilitates development of a relationship within which the preceptor gets to know the individual student. In theoretical terms, when a positive, one to one, relationship is established, the preceptor recognises the student's potential and leads him/her through what Vygotsky identifies as the '*zone of proximal development*' by involving in scaffolded activities. This results in the development of task competence at a pace that would far outstrip unassisted effort by the student. Vygotsky reminds us: '*In collaboration a child can always do more than he can do independently*'. Evidence from this present study suggests that during clinical practice placements students in nursing can achieve more in collaboration with experienced preceptors than they can independently. The extent to which this happens, however, is influenced by the quality of the formal learning support system and the relationship between preceptor and student in clinical practice.

The sociocultural literature presents a view which accentuates the social and cultural genesis and appropriation of knowledge. Learning to become a nurse therefore requires access to the particular social practice and what that practice privileges. Preceptorship not only provides a means of sponsorship into this environment, but

also opportunity for learning through collaboration with an experienced practitioner in patient care.

CHAPTER 7

CHAPTER 7

ISSUES ARISING FROM THE STUDY: POINTERS TO POLICY AND PRACTICE

7.1 Introduction

The aim of this study was to explore student nurses' experience of preceptorship. The purpose was: to develop a theoretical understanding of preceptorship, to analyse the influence of preceptorship on students' learning, and to inform future planning of practice based learning in pre-registration nurse education.

While the initial approach was that of grounded theory, data collection and analysis led to a change in analytical direction which involved bringing a framework of explanation to the data. This approach allowed the data to be explored, viewed and interpreted within a sociocultural perspective on learning.

This study has achieved its aims by illuminating the students' experience of preceptorship. It has clearly identified important elements of preceptorship and how these influence student learning and development. Knowledge and understanding of preceptorship has therefore been advanced on two levels: a detailed account of the student experiences is provided and a theoretical explanation, based on sociocultural theories of learning and development, has been constructed.

This final chapter will briefly recapitulate on the main findings of the study. Limitations will be acknowledged and the implications for future planning in pre-registration nurse education will be discussed.

7.2 Study Findings

A full account of the study findings has been presented in chapter 5 therefore only a brief summary will be revisited here to highlight the implications for future planning.

Without exception the participants acknowledged the positive effect of having a preceptor in the clinical area. Both positive and negative experiences of preceptorship were identified and related. Even when the experience was described as negative, it was still important to have a name, someone to go to should any problems be encountered. This finding supports the need for a formalised system of learning support and the allocation of a named preceptor. The quality of the learning experience was, however, clearly influenced by the individual preceptor and relationship formed as well as by the length of the placement. The majority of placements were recognised as too short by each of the participants.

Every participant identified the need to 'fit in' to each of the clinical areas they were assigned to for practice. It was important to 'fit in' before they could focus on learning and the 'good' preceptor played an important role in assisting this process. As well as positively influencing the process of 'fitting in', the preceptor facilitated student learning by providing structure, guidance, supervision, support and challenge throughout the clinical placement.

The roles of preceptor and student were dynamic. As the student developed in confidence and competence the preceptor moved from role model to supervisor, facilitating greater opportunity for collaborative and autonomous practice. The changing role was perceived by the students as essential to the development of confidence and professional competence to practice.

A theoretical explanation and interpretive analysis of the findings has been presented fully in chapter 6. The process of 'fitting in' was explained through legitimate peripheral participation as described by Lave and Wenger (1991). This allowed for

exploration of the impact of the preceptor on the students' entry into each new clinical placement. When assigned to a preceptor the student presence in care delivery was 'legitimised'. The influence this had on the students' perception of their role and learning is explained. A framework of 'guided participation' (Rogoff 1990) was then introduced to interpret and explain further the process of learning. Using Rogoff's theory, the impact of participation and collaboration in the actual practice of nursing was examined. Participating in care delivery with experienced practitioners involved students in everyday problem solving activities which was perceived by the students as essential to learning. The close relationship between problem-solving and learning in practice is recognised and explained.

7.3 Limitations

Although the aims of the study have been met, limitations are acknowledged. This was a small scale study which focused exclusively on the student nurses' experience of preceptorship. A larger study, to include the perceptions and experiences of preceptors, would add to the body of knowledge of preceptorship.

Among the limitations is the timing of the study, which coincided with changes to the clinical assessment procedures for students. The system of grading clinical practice had been in place but was in the process of changing to a satisfactory/unsatisfactory assessment. Therefore, while students clearly acknowledged the role of the preceptor in assessing practice, the majority of the discussions were dominated by the change in system and the perceptions of fairness and unfairness associated with grading procedures. The extent to which this study informs clinical assessment procedures and practices is, consequently, limited. A more focused study on the preceptor's role in assessment would be recommended.

In addition, the participants were from one college of nursing which had invested in formalising a preceptorship system for all students undertaking the Diploma of Higher Education in Nursing. Collaboration between the college of nursing and the

health board facilitated the release of staff to undertake a five day course of preparation for the role of preceptor. While the investment in collaborative activity is commended, this level of collaboration and preparation of staff is not common practice throughout the country (May et al 1997; Watson and Harris 1999). Findings, therefore, cannot be freely generalised.

While considerable caution needs to be exercised in generalising the specific findings, dimensions of preceptorship and student learning have come into view from the study which would be salient and relevant in different settings. As Bryman and Burgess (1994) acknowledge:

It may require only one remark, one individual's example to unravel the elusive intelligibility of the group or context (p.25).

Analysis of the rich descriptive data has identified how the students learn from participating with, and interacting with, others in day to day nursing practice. In particular, how the need for a preceptor with whom they can work, is essential for illuminating the more tacit, context specific, aspects of patient care which are often difficult to make explicit in less collaborative learning relationships. Over and above advancing knowledge of student experiences of preceptorship, the theoretical framework within which the data has been analysed and situated, captures the complexity of learning within diverse clinical contexts and can therefore inform future practice and policy.

7.4 Information for policy and practice

Length of placement

The recently published government strategy document for nursing, midwifery and health visiting in England, *Making a Difference* (DOH 1999), acknowledges that provision of clinical placements is a vital part of the education process and confirms that every practitioner shares responsibility to support and teach the next generation of nurses and midwives. This report goes on to call for '*higher quality and longer*

placements in a genuinely supportive learning environment' (DOH 1999 p. 27). The call for longer placements within the strategy document is well supported not only within this current study, but also within previous research. As far back as 1981 Melia commented on the issue of placement length. More recently Crawford and Kiger (1999) and Watson and Harris (1999) provided evidence to suggest the length of placement influenced the potential success of the clinical learning process. Indeed, looking back on the literature review, placement length was identified as one of three significant factors which influenced student learning in both the American and the UK context. In relation to preceptorship, the other factors persistently contributing to the experience were: the preceptor-student relationship and preparation for the role of preceptor. It is therefore time to move beyond the rhetoric of longer, more supportive placements and address these important issues.

Resource implications

Factors which facilitate student learning are clearly identified throughout the study and the findings suggest that well prepared preceptors influence the quality of student learning. These findings can therefore inform decisions relating to course structure and placement length as well as the implementation of learning support systems. However, while these findings can be used to inform policy and decision making relating to clinical practice, the implications regarding resources need to be acknowledged.

In the ideal situation each student nurse would be assigned to an individual preceptor for a substantial period of clinical experience. The preceptor would have been selected for this role because of clinical expertise and interest in teaching. Having undertaken a course of preparation, which included insight into the students' course and general principles of teaching and learning, the preceptor would be supported in the role by a named lecturer from the university as well as by nursing service managers. The preceptor would be motivated, interested and keen to facilitate students' learning by involving them in high quality individualised nursing care. In return the student would develop in competence and in confidence at a pace that

would far outstrip less collaborative, informal approaches to learning in clinical practice. The length of placement and continuity of preceptor would allow for the initial 'fitting in' period, the development of a relationship in which trust can be established, and learning and development can take place. Through the process of guided participation with a skilled preceptor, the student would contribute to patient care, developing in knowledge, skill, confidence and professional competence.

In reality, however, the situation is very different. The review of the literature indicated a clear commitment to the preceptor role when individuals perceived there to be benefits in the form of support and recognition for the role. The earlier literature, nevertheless, demonstrates that most preceptors are selected on the basis of who is available, rather than who is suitable for the role (Myrick and Barret 1994). The more recent literature suggests this is still the case. A survey by Watson and Harris (1999) revealed that only about one third of 'mentors' in their study had volunteered for the role. These authors also identify lack of preparation, and lack of understanding, for the 'mentor' role, resulting in frustration among 'mentors' and students. Frustration among 'mentors' is also related to the lack of time available for teaching and supervising students. In the context of the present study, the majority of preceptors are working in an already overstrained health care system where prioritising and rationing of resources are daily issues. The influence of the preceptor's attitude and the overall staff morale on the students' learning experience is clearly evident. When resources, particularly time, are limited, provision of patient care takes priority over students' education and supervision needs (Watson and Harris 1999). Few NHS Trusts make provision for the time preceptors spend with their students. Indeed, Watson and Harris (1999) report that 77% of Trust Executive officers who participated in their study 'did not make a specific allocation within their staffing calculations to allow mentors time to provide students with support' (p. 146). There is a resource issue relating to preceptorship, but the need to provide high quality practice and educational experiences for students is recognised as an essential element in improving the overall quality of nursing practice (UKCC 1999; DOH 1999) and should therefore be recognised as such in resource allocation.

Collaboration

The resource issues identified above are clearly not only the responsibility of the nursing service providers but also of the Higher Education Institution (HEI). The quality and level of support experienced by preceptors demands attention (May et al 1997; Watson and Harris 1999). Inconsistency in support does not relate only to that from immediate nursing managers but also from the HEI where the students are based. Recognition of the preceptor role may be demonstrated through a variety of means such as time allocation and support by managers and involvement in continuing education by HEIs. Responsibility for student learning in practice must be a joint endeavour between the student, the preceptors, the managers and teachers. Collaboration is therefore essential at each of these levels. Notwithstanding the need for collaboration at different levels, the findings from this study could be used to inform nurse managers and practitioners of their influence on student learning. In addition, they can be used by HEIs to support and underpin courses of preparation for preceptors.

Preparation of preceptors

The need for preparation for the role of preceptor is well established throughout the literature. The theoretical explanation which has been constructed to explain the student nurses' experience of preceptorship in this study could be used as a framework within which preceptor preparation courses are developed. The concept of legitimate peripheral participation could be introduced to highlight student perceptions of 'fitting in' and explain the significance of sponsorship to the process of learning. Guided participation would then be used to illustrate the effect of interpersonal processes such as: communication, collaboration and participation on students' learning experiences. Understanding of these processes may help registered nurses realise the significance of clinical practice and the influence that each individual has on a student's learning.

7.5 Summary and Conclusion

In examining the essence of nursing, Virginia Henderson (1980) said:

No experience offered by educators to students is as important as seeing expert nurses practice; then participating in this practice, and finally having an opportunity to practice as effectively as they can themselves, with help from the expert (p.254)

Twenty years on, participants in this present study support the view of Virginia Henderson and recognise the preceptor as the key influence on their experience of learning nursing. This study provides evidence to suggest that a formal preceptorship system and well prepared preceptors have a positive influence on the quality of student learning.

The quality of student learning is undoubtedly influenced when assigned to a 'good' preceptor. The quality of the preceptorship experience is, moreover, influenced by the individual preceptor and the level of support and preparation the preceptor receives for the role. Provision of a formal preceptorship system demands recognition and commitment from both nursing service providers and HEIs.

The resource implications have already been identified. However, preceptorship must be seen as an investment. Not only an investment in the quality of education for student nurses, but also an investment in the future of nursing. Never before has the nurse's role been so dynamic and so complex. Nurses are taking increasing responsibility for management and leadership in the wider health care arena. In order to meet the ever changing demands and to prepare nurses for the future we must start with pre-registration learning support. If we provide a supportive learning environment for our students, then it may be that we can create a culture which embraces collaboration, and recognises the value of learning through guided participation. This could extend into post-registration experience and encourage life long learning and development in nursing practice. The potential returns from the

investment would ultimately be reflected in the quality of patient care. Improving nurse education must be about improving patient care.

In order to maximise learning through *guided participation* the length of clinical placements must, however, be reconsidered and lengthened. The challenge thereafter lies in encouraging registered nurses to share their thinking, their personal reflections and accounts of their practice with students and thus actualise their potential to positively influence the students' learning experience. The concepts of *legitimate peripheral participation* and *guided participation* could be used to underpin the preparation of nurses for their role in supporting and facilitating student learning. Responsibility for supporting students' learning in practice, however, must be valued as a joint endeavour between educationalists and service providers.

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APPENDIX 1

Colette Ferguson
Department of Nursing Studies
University of Edinburgh
Room 4, 2nd Floor
12 Buccleuch Place
Edinburgh
EH8 9JU
27.8.96

Acting Principal
College of nursing and Midwifery

Dear

Preceptorship: The Student Experience

Thank you for your letter dated 23.8.96 confirming your support for the above study.

As previously discussed, the research will focus on preceptorship and the student's experience of learning from practice. The study will involve interviewing a sample of students, I therefore seek your permission to contact students within the college and carry out a series of interviews. Confidentiality is assured regarding the research and this assurance will be extended to each participant.

I look forward to hearing from you and once again thank you for your support in this endeavour,

Yours sincerely,

Colette Ferguson.

Dear Colette

Research Study: The Student Experience of Preceptorship

I am in receipt of your letter dated 27.8.96. To facilitate the above, I am more than pleased to approve the forthcoming interviews with students. The work you will be undertaking represents an extremely valuable area of research, both in terms of The College and the local providers of Nursing/Midwifery services.

I would be grateful if you would, at six monthly intervals, submit a brief summary of input and progress achieved, as regards the ongoing study.

I would reiterate my best wishes for your research endeavour and assure you of my availability should you wish further support and assistance.

Yours sincerely

Acting Principal.

APPENDIX 2



Colette Ferguson
Department of Nursing Studies
University of Edinburgh
Room 4, 2nd Floor
12 Buccleuch Place
Edinburgh
EH8 9JU

7th April 1997

Dear

I am on sabbatical leave from the College of Nursing at present studying at the University of Edinburgh. I am conducting a study of student's experience of Preceptorship and the only way to develop relevant knowledge and understanding is to ask the students and listen to their experiences. I am therefore inviting you to participate in this study. Your contribution would be appreciated and considered essential to the development of knowledge about Preceptorship.

I would propose to meet with you, at a time and place of your choice, and discuss your experiences of learning in the practice setting. The meeting would be very informal and would last approximately one hour. Confidentiality is assured and no material relating to the meeting will be accessible to anyone other than myself. In reporting the study anonymity will be maintained.

As you are nearing the end of your course you may not benefit directly from the research, however, you will be helping to inform decisions about future use of Preceptorship therefore influencing the quality of future students' practice experience. I have drawn a random sample from your class and hope you will agree to participate. Please return the tear off slip to me in the envelope provided by Thursday 17th April 1997.

I will then contact you by telephone to arrange a suitable date and time to meet. Should you have any questions please do not hesitate to contact me at 01236 432991.

Yours sincerely,

Colette Ferguson

Preceptorship : The Student Experience

I agree to participate in the above study.

Signed:

Date:

APPENDIX 3

APPENDIX 4

Dear ,

Preceptorship : The Student Experience

Thank you for agreeing to participate in the above study. I now confirm our meeting on at As agreed I shall tape record the interview.

Yours sincerely,

Colette Ferguson

APPENDIX 5

July 9th

Interview No 1





APPENDIX 6

would say whether you were on the right lines ... so it was good that way ... and when you got it right it made you feel so good ... I enjoyed that type of learning.'

Work organisation

As well as the overall atmosphere, the organisation of work facilitates student learning in the community through continuity and travel time:

'... in the community you do have that wee bit more time as you're going from different places you are visiting ... they would talk things over with you, ... just simple things like at the start he would explain things to you and then as you were going along he would say ... well what did you notice in there? What did you think? How do you feel that client has adapted to this? Or what do you think his symptoms are? Or even just simple things like, what do you think his illness is? ... you know ... these are the kind of things ... I feel in the community they do have more time ... just probably because of travelling from one house to another or from place of work to the house ... you do have more time to talk where you don't have that in the wards.'

Whilst this strategy of questioning is used in many clinical learning situations, travelling in the community provides a captive environment for interaction and reflection between preceptor and student. This travel time is highly valued by the students and seen as time for reflection, talking through and exploring individual patient care. This time is identified as a teaching and learning situation by the student and strategically used as such by the 'good preceptor'.

Throughout the placement the student is exposed to a diverse and complex range of practice. Changes in the health care system such as day surgery and shorter hospital stay for patients has raised the level of acute care in the community. Experience of skills such as removal of sutures and dressings is no longer assured during hospital placements, but is more readily accessible during community care. The impact this has on nurse education is reflected in the following comment:

'out in community it's totally different because there's totally different types of dressings ... and taking out stitches, in the hospital now most patients are discharged before the stitches or clips come out so most of my experience as far as that's concerned has been in the community ... and then you've got your general nursing care and your eye drops and things like that so

you're getting a touch of everything all the time.'

The majority of participants acknowledge the vast range of experience available during community placements.

Family centred care

As well as gaining experience in psychomotor skills, student awareness of family needs and the social implications of ill health are raised. The majority of participants commented on their changing perception not only of the patient as an individual, but as a family member, in their own home. The needs of family and other carers are identified and the implications for care planning recognised. Not only is the perception of the patient extended but also the perception of the role of the nurse. In contrast to hospital placements the student now experiences care giving in a patient/family controlled environment and identifies the need for more collaborative decision making. Many participants use the phrase 'we are a guest in the patient's home' as a means of communicating the different power relationship between the nurse and patient. One student recognised the complexity of care planning in the home when he said:

'and I think in the district again ... dealing with people ... managing people in their own environment ... because you might only have one patient but you might have about three or four other persons in the house involved ... I think it's about their personality, their way of approaching patients and talking to the family, especially in terminal cases ... there is a lot of skill involved.'

This comment not only captured the importance of family but also the skill of the nurse in establishing a therapeutic relationship. Many participants identified the impact of community experience on the development of communication skills:

'practice as well ... I've been in to a terminal case once ... I went back into the house after the person had died ... and it was again trying to be empathetic and sympathetic and ... just copying and approaching ... and talking to them in the same way that the district nurse did ... skills like that ... that's (an) important skill.'

This quotation highlights the significance of role modelling in practice

and is reinforced by another student who said:

'like a sponge ... you just soaked everything that they were doing, you watched them, you listened to them, you followed them ... just everything that they were doing ...'

The above comments illustrate the influence of community practice on student learning. The process of learning how to approach and communicate with patients, negotiating their role in a relationship rather than expecting the patient and family to acquiesce to the demands and requirements of the health care system, is highlighted. Bysshe (1990) previously recognised: 'the fact that the nurse is viewed as a guest in the home sets the relationship on a completely different footing from that in hospital.'

From the present study it appears that three significant factors influence the student experience of preceptorship in the community:

- length of placement
- course stage
- continuity

The student is assigned to a community nurse preceptor for four weeks in semester five (at the beginning of the third year) and returns in semester six for ten weeks. Semester six is the final six months prior to registration.

During the four week placement the preceptor and student work together in delivering care. When the student returns for the ten week placement, a plan is negotiated whereby the preceptor gives the student responsibility for caring for a small group of patients in order to gain experience in planning, delivering and evaluating care. The student learns through collaboration, practice, reflection on and discussion of care.

The continuity from part five to six as well as the length of placement allows the preceptor to get to know the student, assess his/her level of competence and facilitate development by allowing him/her to participate more fully as a member of the team. This also allows the student to 'fit in' to the team and feel more comfortable which in turn influences confidence and stimulates learning. The value of continuity is clearly reflected in the following student statement:

'... because your preceptor knows what you have done ... what you are able to do

and ... gives you a wee bit more guidance and ... you can go on and do something else ... because she knows you are capable of doing it ... whereas if you are doing a dressing with somebody one day and a different person the next day; they don't know that you managed to do it the day before.'

Continuity allows the preceptor to assess the individual student's ability, limitations and readiness to carry out care without direct supervision. As the community nurses spend more time with the student it would appear that they are less apprehensive about allowing the student to participate actively without direct supervision. Hallett *et al.* (1995) acknowledges community nurses' anxiety about allowing students to carry out unaccompanied visits, but goes on to say that the same nurses insist these decisions should be made by them rather than anybody else because they are responsible for the welfare of their patients.

Experience of unaccompanied visits is of particular importance as participation in care delivery and 'getting to do' is identified by the students as the most powerful influence on learning in practice. This finding is consistent with the work of Mackenzie (1992) who asserts that learning by doing is crucial to the students who talk of 'itching' to be involved, learning more by themselves and seeking to increase independence by testing out their future role alone in the patient context. The students in the study acknowledge the challenge involved when given a small group of patients to look after. The influence this has on learning is identified:

'... it makes you think a lot more ... it's very challenging ... much more ... because before everything was done for you, it was put on a plate and you just went and done it ... whereas now ... you've got to prioritise ... it gives you something more to think about ... it is more challenging.'

Summary

Analysis of the data highlights the valuable experience gained through the one to one relationship with the preceptor during community practice. The role of the nurse within the primary health care team facilitates learning the essential skills of communication, collaboration and team work required for practice.

The student is exposed to a wide variety of experiences which facilitate

development of cognitive, psychomotor as well as affective skills. When assigned to a 'good preceptor' the participants express the positive nature of the experience, the impact on learning and the effect this has on development of confidence and competence.

Preceptorship has the potential to enhance learning. For this potential to be realised considerable investment in preparation and support for the role is required. Students of nursing can then be afforded the opportunity to observe expert role models giving care in the home, help these experts give care and progressively assume responsibility for nursing care in the home. Only then can the student experience the satisfaction of giving effective care in this environment and recognise when it is ineffective. Pre-registration education must address this challenge by developing and maximising the student experience of home care nursing, so that tomorrow's nurses are prepared to meet patient needs wherever the context of care.

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Learning in the home care setting

Colette Ferguson, Dorothy Whyte and Charles Anderson describe their preliminary findings from a qualitative research study which aimed to discover student nurse experiences of preceptorship during their community placement.

Key words:
Preceptorship
Community practice
Student experiences and perceptions

The government white paper 'Designed to Care' (DoH, 1997) proposed a primary health care led National Health Service. Primary health care development will mean massive changes in the deployment and work patterns of nurses and will require a major reorientation of nursing education (Clark, 1997). Preparation for such a role must begin in pre-registration nursing courses. In this article the potential of preceptorship as a strategy for facilitating student learning will be explored. A qualitative research study is underway and some preliminary findings relating to the student experience of preceptorship during community practice will be discussed.

Community placements

Within traditional nursing programmes the student experience of community practice was often limited and fragmented. A short period of time, normally four to eight weeks, was spent as an observer with the district nurse, health visitor and school nurse. Much of this time was spent visiting a variety of agencies and little time was spent with the district nurse in actual care delivery. In response to Project 2000 (UKCC, 1986), and the implementation of the Diploma of Higher Education in Nursing, the changing focus of health care has been addressed to some extent through an increase in primary health care and community practice placements. The national evaluation of Project 2000 (May *et al.*, 1997), however, recognises the need for further research to evaluate the outcome of community practice experience in Scotland.

In one college 50 per cent of all clinical practice is community based, four weeks are spent with the health visitor and approximately fourteen weeks spent with the district nurse, participating in care. Before implementing the diploma courses it was recognised that students would require a formal system of support in practice, in order to facilitate learning. Following discussion,

informed by a review of the literature, a preceptorship system was initiated. A qualitative research study is now underway to explore the value of this initiative. Some of the preliminary findings related to the community setting will be outlined and significant challenges for the preparation and education of nurses will be highlighted. Preceptorship is defined as:

'... an individualised teaching/learning method (in which) each student is assigned to a particular preceptor ... so that he or she can experience day to day practice with a role model and resource person immediately available within the clinical setting'

(Chickerella & Lutz, 1981)

The preceptor is the nurse who teaches or instructs by demonstrating and applying 'precepts' through care giving. A precept is defined as a 'maxim' or a general rule for action. Given that nursing practice is more than the sum of component parts, this would appear to be a potentially invaluable strategy for facilitating learning.

In the UK, practitioner preparation for supporting 'project 2000' students was clearly identified in the exploratory study by Hallet *et al.*, (1995) who noted that:

'district nurses and health visitors require adequate preparation and training for the work with project 2000 students. They also require effective communication links with colleges of nursing.'

Within this college of nursing each practitioner who was supporting students during practice placement had undertaken a five day course of preparation for the role of preceptor. The course included: dissemination of information and discussion on contemporary developments in nurse and midwifery education; underpinning theories and skill supporting practice based learning; workshops on learning contracts and assessing competence. The aim was to

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develop appropriate knowledge and skill as well as providing a forum for discussion and sharing of experience.

At this stage a grounded theory approach was adopted to explore the student experience of preceptorship. Twenty-five students in the final year of their course were interviewed. Theoretical sampling in conjunction with constant comparative analysis was ongoing. This article will now focus on some of the preliminary findings related to community practice and be guided by three questions:

- Did students perceive preceptorship as facilitating learning?
- What were students experiencing in preceptorship?
- What were students learning?

Each of the participants in the study acknowledged the impact an individual preceptor may have had on their learning. Characteristics of the 'good' and the 'bad' preceptor as perceived by the students were described and discussed in relation to the quality of learning.

The students perceived that the preceptor who took time to clarify expectations and discussed individual aims, objectives and goals, provided the basis for a positive learning experience. In contrast the 'bad preceptor', described as uninterested and unapproachable, was reluctant to discuss or facilitate learning outcomes. When the student was assigned to a 'good preceptor' the outcome of the placement was positively influenced. The student worked with the preceptor and learned through watching, listening, asking questions, sharing experience and collaborating in care giving.

According to the data, individual preceptors have the potential to influence the development of attitudes and values towards caring for patients and families. In relation to practice the 'good preceptor' was seen as a positive role model, someone who demonstrated good patient care as in the following comment:

'I think the ones that I've found to be really good preceptors were really caring towards the patients ... and I think maybe because they were just caring people ... and I've stood beside them when they've been dealing with patients and I've thought ... oh God, I want to be like you ... I think they are just wonderful people ... and to the rest of the staff they're just ... they care ...'

These preceptors worked with the students, involved them in care delivery and actively provided experiences. In the words of another student: *'they allowed you to do'* and were willing to share their knowledge, skill and expertise through discussion, reflection and narrative. The impact this had on student learning was recognised in the following statement:

'I think you learn everything ... from obviously the practical skills ... you learn an awful lot ... you rely on them to show you the correct way ... you learn ... I suppose you sometimes develop some of their attitudes ... it does come across on you ... so basically the whole nursing you learn from them'

It became clear from the participants that individual preceptors had the potential to influence learning in the psychomotor, cognitive and affective domains of nursing practice.

Without exception the participants discussed differences between the experience of preceptorship in hospital and community practice. The most significant differences were related to the environment and to the relationships formed.

The overall environment within the community was recognised by students as being less formal than the hospital and this influenced the ease with which they could 'fit in'. This is consistent with the work of Griffiths and Luker (1994) who acknowledge that, nursing in the community, with higher numbers of qualified staff, has traditionally had a flatter hierarchy than hospital nursing, thus enabling collegial intraprofessional relationships to develop. The influence of this less formal atmosphere is reflected in comments such as:

'they are on first name terms on the community ... it's more relaxed ... it makes you feel more relaxed'. When 'relaxed' the student is more likely to ask questions in order to develop knowledge and understanding and learn from practice. Another student said: 'because you feel more relaxed to learn ... you are not uptight about doing things ... I feel more confident in the community than I do in the wards.'

Initially the student is with the preceptor at all times and learns through observation, listening and reflecting. As well as providing an opportunity to ask questions, being with the preceptor and working with the preceptor allows for those learning opportunities which present themselves serendipitously. The

preceptor can use the 'teachable moment' as described by Brookfield (1986) addressing issues and situations as they arise. This is of particular relevance in the home care setting where unplanned activities and unpredictable situations are the norm. The less structured environment can present a culture shock to the student nurse and the home can be more 'distracting' than traditional clinical settings not least because of family members, pets, radio or television influence. Within this environment the student can learn to adapt and develop individualised strategies to meet patient and family needs.

The relationship

The nature of care delivery in the community allows for the ideal one-to-one preceptor student ratio to be realised. Given the structure and organisation of community nursing the student is assigned to the nurse who is prepared as a preceptor. The student works with the preceptor and participates in assessing, planning, implementing and evaluating care over an extended period. The positive nature of such an experience is identified and reflected in students comments such as:

'preceptorship works best out in the community because you are always with your preceptor ... and I feel you learn ... you can ask questions like ... if you are doing something on the spur of the moment you can ask a question and your preceptor is there to answer it ... she is not running away ... I've learned a lot more out in the community than I have in the wards ... being with the preceptor at all times ... and you are getting a lot of experience in doing things.'

The one-to-one relationship provides support for the student and influences the ease and freedom with which questions may be addressed. Although the participants felt more comfortable and relaxed within the community setting they acknowledged the placement as challenging and stimulating in relation to learning. Many participants commented on strategies used by the community nurse preceptor which stimulated learning, for example:

'... before we went in (to the house) he would say I'm not going to tell you anything about them, I want you to make your own observations and see what you come up with ... so that was good, it made me think about it ... and then you come out and you give him the run down and he